TAX ISSUES AFFECTING THE HEALTH AND SAFETY OF INNER-CITY RESIDENTS AND OTHER MISCELLANEOUS HEALTH-RELATED TAX ISSUES

HEARING

BEFORE THE

SUBCOMMITTEE ON SELECT REVENUE MEASURES

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

JUNE 29, 1993

Serial 103–49

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SUBMISSIONS FOR THE RECORD

TAX ISSUES AFFECTING THE HEALTH AND SAFETY OF INNER-CITY RESIDENTS AND OTHER MISCELLANEOUS HEALTH-RELATED TAX ISSUES

TUESDAY, JUNE 29, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON SELECT REVENUE MEASURES,
Washington, D.C.

The subcommittee met, pursuant to call, at 12:45 p.m., in room 1100, Longworth House Office Building, Hon. Charles B. Rangel (chairman of the subcommittee) presiding.

[Press releases announcing the hearing follow:]

FOR IMMEDIATE RELEASE
TUESDAY, JUNE 1, 1993

PRESS RELEASE #3
SUBCOMMITTEE ON SELECT REVENUE MEASURES
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-1721

THE HONORABLE CHARLES B. RANGEL (D., N.Y.), CHAIRMAN, SUBCOMMITTEE ON SELECT REVENUE MEASURES, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A PUBLIC HEARING ON TAX ISSUES AFFECTING THE HEALTH AND SAFETY OF INNER-CITY RESIDENTS AND OTHER MISCELLANEOUS HEALTH-RELATED TAX ISSUES

The Honorable Charles B. Rangel (D., N.Y.), Chairman, Subcommittee on Select Revenue Measures, Committee on Ways and Means, U.S. House of Representatives, today announced a public hearing on tax issues affecting the health and safety of residents of inner-city and other distressed neighborhoods in this country, and on other miscellaneous health-related tax issues. A specific date for the hearing will be announced in a subsequent press release.

In announcing this hearing, Chairman Rangel stated: "Residents of distressed neighborhoods in this country face severe and relatively unique threats to their well-being on a daily basis because of the difficult health and social problems confronting these neighborhoods. The Subcommittee is holding this hearing to focus attention on these problems and on possible ways to ameliorate them through the use of the tax laws."

In particular, the Subcommittee is interested in receiving testimony on proposals to tax firearms, drugs, and unsafe needles, as well as proposals to enhance the provision of charity care and other services benefiting the community by tax-exempt hospitals.

Among the specific proposals relating to distressed neighborhoods which the Subcommittee will consider, is a proposal to increase the excise tax on handguns to 20 percent and all other firearms to 22 percent, with 50 percent of total revenue generated to be deposited in the Hospital Gunshot Cost Containment Trust Fund. Another proposal in this area on which the Subcommittee hopes to receive testimony is a proposal to impose a tax for three years (1997-1999) on needle devices the Food and Drug Administration determines to be unsafe. However, the Subcommittee invites witnesses to provide alternative solutions to the problems addressed by these proposals as well.

In addition, the Subcommittee solicits testimony on the following miscellaneous health-related tax issues:

(1) the treatment of health maintenance organizations (HMOs) and charitable risk pools (i.e., nonprofit organizations that provide low-cost liability coverage to tax-exempt member charities) under section 501(m) of the Internal Revenue Code;

(2) a proposal to encourage organ donations through the inclusion of organ donor information in materials sent to taxpayers by the Department of the Treasury; and

(3) the impact of the loss reserve discounting rules in Revenue Procedure 92-76 on medical malpractice insurers.

It is anticipated that the Administration will testify at this hearing, along with other invited witnesses and certain interested members of the public.

(MORE)

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD:

Individuals and organizations interested in presenting oral testimony before the Committee must submit their requests to be heard by telephone to Harriett Lawler, Diane Kirkland, or Karen Ponzurick [(202) 225-1721] no later than Tuesday, June 15, 1993, to be followed by a formal written request to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The Subcommittee staff will notify by telephone those scheduled to appear as soon as possible after the filing deadline. Any questions concerning a scheduled appearance should be directed to the Subcommittee [(202) 225-9710].

Persons and organizations having a common position are urged to make every effort to designate one spokesperson to represent them in order for the Subcommittee to hear as many points of view as possible. Time for oral presentations will be strictly limited with the understanding that a more detailed statement may be included in the printed record of the hearing (see formatting requirements below). This process will afford more time for members to question witnesses. In addition, witnesses may be grouped as panelists with strict time limitations for each panelist.

In order to assure the most productive use of the limited amount of time available to question hearing witnesses, all witnesses scheduled to appear before the Subcommittee are required to submit 200 copies of their prepared statements to the Subcommittee office, room 1105 Longworth House Office Building, at least 24 hours in advance of their scheduled appearance. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Persons submitting written statements for the printed record of the hearing should submit at least six (6) copies by the close of business on the day two weeks after the date of the hearing, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements for the record of the printed hearing wish to have their statements distributed to the press and the interested public, they may provide 100 additional copies for this purpose to the Subcommittee office, room 1105 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

* * * * *

FOR IMMEDIATE RELEASE
THURSDAY, JUNE 10, 1993

PRESS RELEASE #5
SUBCOMMITTEE ON SELECT REVENUE MEASURES
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-1721

THE HONORABLE CHARLES B. RANGEL (D., N.Y.), CHAIRMAN, SUBCOMMITTEE ON SELECT REVENUE MEASURES, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES THE DATE OF THE HEARING ON TAX ISSUES AFFECTING THE HEALTH AND SAFETY OF INNER-CITY RESIDENTS AND OTHER MISCELLANEOUS HEALTH-RELATED TAX ISSUES

The Honorable Charles B. Rangel (D., N.Y.), Chairman, Subcommittee on Select Revenue Measures, Committee on Ways and Means, U.S. House of Representatives, announced today that the date for the Subcommittee's hearing on tax issues affecting the health and safety of inner-city residents and other miscellaneous health-related tax issues is Tuesday, June 29, 1993, beginning at 11:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building.

This hearing was announced, and background information was provided, in press release #3, dated June 1, 1993. As noted in that press release, the deadline for requests to be heard is Tuesday, June 15, 1993. Statements for the record relating to miscellaneous health-related tax issues must be submitted by the close of business on June 29, 1993.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Persons submitting written statements for the printed record of the hearing should submit at least six (6) copies by the close of business on Tuesday, June 29, 1993, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements for the record of the printed hearing wish to have their statements distributed to the press and the interested public, they may provide 100 additional copies for this purpose to the Subcommittee office, room 1105 Longworth House Office Building, before the hearing begins.

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Chairman RANGEL. The subcommittee will come to order. My apologies to the witnesses. I think that you are entitled to some type of an explanation, and the truth is that the House is trying desperately to complete its appropriations bills before we leave here for the Fourth of July. That means that a number of votes had to be taken this morning.

We will shortly start the hearing. We are starting today to review legislation and suggestions as they relate to the health situation that exists in the poorer communities throughout our Nation. We have found that one of the major problems facing us as it relates to the deficit is the amount of money that we have to spend in poor communities because so many of the residents only know public hospital and public health facilities as their sole means for any type of health care. We also note the fact that many of these people don't have health insurance and therefore are not involved in preventive health care. So many of these underserved enter the hospitals going straight to intensive care units which cost up to $5,000 a day compared with the regular cost of $600 a day. The problems with addicts, children born addicted, drug problems, heart disease, and kidney and liver failures connected with alcohol and drug abuse, and the violence and the gunshot wounds, all of these things put a heavy burden on our health system and not only in terms of lost productivity and loss of life, but certainly loss of a lot of dollars that could be saved if we can intervene at some point.

We have several distinguished witnesses that have faced these problems, sometimes politically, sometimes personally. Others have researched them, and they are willing to address these problems and share with us what solutions or partial solutions they think can be obtained by legislation, and so with that in mind I ask my colleagues and Mr. Hancock for any opening statements that they may have.

Mr. Payne.

Mr. PAYNE. I don't have any.

Chairman RANGEL. Then we are anxious to hear from a colleague from this committee that is held in great esteem, not only for his personal accomplishments, but for his relationship with the Chairman, both being from Chicago, and having known exactly firsthand the problems that our cities and inner cities are facing. We are glad that you have taken time, our colleague, to share with us your views on this most important subject.

Mr. Reynolds.

STATEMENT OF HON. MEL REYNOLDS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. REYNOLDS. Thank you, Mr. Chairman and members of the committee. Mr. Chairman, distinguished members of the subcommittee, thank you very much for the opportunity to testify this afternoon. Today's hearing on tax measures affecting the health and safety of inner city residents is much needed. I applaud the subcommittee for focusing on this issue.

I appear before the subcommittee today on behalf of legislation I have introduced, H.R. 737, which effectively doubles the current excise tax on handguns and other firearms from 10 percent on

handguns and 11 percent on all other firearms to 20 percent. All of the new revenues collected from this tax would be dedicated to the Hospital Gunshot Cost Relief Trust Fund, which is also established by this legislation. Moneys within the trust fund would be made available in the form of grants to urban hospitals to help them alleviate the costs associated with treating uninsured gunshot victims. According to the Joint Tax Committee's estimate, this legislation would raise almost $350 million over 5 years.

Mr. Chairman, it is time that manufacturers of inherently dangerous products, such as firearms, share in the costs incurred by our trauma care system for the treatment of uninsured gunshot victims.

All across America, trauma units are closing as a result of this uninsured gunshot victim crisis. A total of 60 of the 370 designated level 1 trauma care centers closed in the 5 years before 1991. In 1992 there were five trauma centers for the entire State of Virginia, two level 1 trauma care centers in the entire State of Michigan, and one for the entire 620-square-mile area of Houston, Tex. A Sacramento Bee series in 1989 noted that since 1980, 12 trauma units, 9 in Los Angeles alone, have dropped their trauma designations.

In my hometown of Chicago, there are no adult trauma care centers on the south side, none. Of the 10 trauma care centers serving metropolitan Chicago in 1986, four closed within the next 4 years. The remaining six centers, which treated an estimated 10,000 trauma patients in 1991, lost a total of $12 million that year. Humana-Michael Reese Hospital left the system after suffering a $2 million loss in 1990.

If an adult needs trauma care on the south side of Chicago, he or she must be transported to Cook County Hospital. To dramatize that in real terms, 2 weeks ago in Chicago a 16-year-old child was shot on 91st and Commercial and was taken on a 30-minute ambulance ride. He died on arrival at the hospital. They went by a hospital that was only 2 minutes away from the shooting. Had he been able to have been taken to that hospital, he would have survived. They went all the way to Christ Hospital out of the city. These are the kind of real life things that happen every day in Chicago.

Those that continue to serve as trauma care centers find the number of uninsured gunshot victims growing, as well as the cost of treating their injuries. One of the key factors contributing to the spiraling cost of treatment is the increased incidence of multiple gunshot wounds.

According to an article in the June 1992 "Journal of the American Medical Association," 25 percent of gunshot victims treated at Cook County Hospital in 1982 had been shot only once, usually with a low velocity bullet. In 1991, 25 percent of the gunshot victims were treated for multiple wounds, many of which were made by high velocity bullets.

The cost of treating multiple gunshot wounds can be staggering, and fatal for an inner city trauma care center. The same journal article states that the average cost of treating a trauma patient at Mount Sinai Hospital in Chicago in 1990 was in excess of $12,000. Because Medicaid only reimbursed about $4,200, the hospital lost approximately $8,000 per Medicaid patient.

To add to the problem, more gunshot victims around the country are not covered by Medicaid. Again, according to the article, the average age of patients admitted to Mount Sinai in 1991 was 25 years old. Ninety-three percent of those patients were male. Young males are not eligible for Medicaid.

Trauma centers must admit all patients, regardless of their ability to pay. As the proportion of uninsured patients entering trauma care centers grows, and their average age declines while the number of gunshot wounds per patient multiplies, we are facing a catastrophe in our Nation's trauma care system.

Already, the cost of treating uninsured gunshot patients nationwide exceeds $4 billion annually, according to the Chair of the 1991 Advisory Council on Social Security. While initial treatment of a gunshot wound can range from $6,000 to $15,000, long-term care for gunshot victims who are paralyzed or suffer other long-term disabilities can run into the millions. Some hospitals are responding to such trends.

The Schwab Rehabilitation Hospital in Chicago recently opened a 12-bed spinal cord injury unit specifically for victims of gunfire. Can there be any sadder commentary on the present state of society that we have to open whole units and wings of hospitals specifically for gunshot victims?

Mr. Chairman, my legislation holds the manufacturer responsible for the tremendous costs associated with guns. Titles I and II of the bill propose holding firearm manufacturers strictly liable for their product, while title III, the title we are considering today, doubles the excise tax. The current excise tax rate has not been raised since 1940 in the case of handguns, and 1954 in the case of all other firearms. Even at such low rates, the excise tax on firearms generated $123 million in revenue in 1991. At present, 100 percent of that revenue is dedicated to aid State wildlife programs.

My proposal would not touch that program. It simply recognizes that the cost of guns to the Nation's trauma care network has been and continues to be staggering. Without some relief for hospitals that struggle to remain a part of the system, we will in short order face a wholesale shutdown of the Nation's trauma care system.

Inner city neighborhoods, as well as poor, urban, and minority communities, already face limited access to health care and comprise a disproportionate percentage of uninsured Americans. The National Center for Health Statistics concluded that firearm homicide was the leading cause of death for black males ages 15 through 19. We are losing a generation of potential leaders due to guns.

The National Rifle Association has steadfastly opposed any and all measures to hold manufacturers of firearms responsible for the impact guns have on society. Theirs is a fundamentally irresponsible view. For us to keep our head in the sand while our children are being injured, maimed and killed by guns is morally reprehensible. My proposal will help us start down the road to saving our children, helping our communities, and supporting our trauma care system. The cost of inaction is just simply too great, Mr. Chairman. I thank my colleagues.

Chairman RANGEL. Thank you. You might want to take this a step further. I visited not too long ago one of my hospitals for the

chronically ill. The hospital director was encouraging me to find apartments and to get Federal funding for housekeeping for the large number of youth that were in this hospital that are fully or partially paralyzed. These are the people that you are talking about. The logic is that if indeed in our hospitals the reimbursement is $600 a day, then we would be paying just for ordinary stay in the hospital $219,000 a year. So it is easy to persuade me that a kid who has been in the hospital a year or two and has been trained therapeutically to be of some assistance to him or herself, that if you have got them a cook and a housekeeper and an apartment, it is cheaper than paying a quarter of a million dollars to have them in the hospital. So that even if you can't strike compassion, just from an economic point of view and a deficit reduction point of view, the person has already received a quarter of a million dollars in health care before, they even go into therapy.

I assume that your theory of a gun tax would be funds to be used for gunshot wounds is pretty closely allied with the theory of taxing cigarettes in order to try to pay some of the cost for lung cancer. Is that it?

Mr. REYNOLDS. Well, I believe strongly that as a priority we ought to look at guns. I would not be averse to discussing or considering taxing cigarettes as it relates to health care.

Chairman RANGEL. Well, have you heard besides the ordinary objections to gun control, any unique arguments against your proposal as it relates to excise taxes?

Mr. REYNOLDS. Well, what is interesting about it is we have heard a lot of opposition from the National Rifle Association about what we are trying to do, but I have not found any of it compelling in the sense that—and I have tried to be as objective as possible, but when you look at the fact that taxes have not been raised on guns, handguns since 1940 and all other weapons since 1954, it appears to me that this is just something that has slipped through the cracks and folks just haven't focused on it, and they have all the money—I pretty much vote for the environmentalist cause, but when you consider now that 100 percent of the money goes to wildlife protection and organizations, that is not living in the reality of 1993 or 1992, when we are being drained $4 billion a year. All of us are paying for that right now in the city of Chicago.

Last year in 1992 every single day in Chicago, 40 people were shot, and 2 died. Every 34 minutes somebody is shot in the city of Chicago. I am talking about shifting the burden from the average person that doesn't have anything to do with guns who is paying for this currently to the people who actually are in the business of making a living and making money and making their life in the business. Let's shift this burden of cost, of rehab, of trauma centers to them, and some folks think that, well, I am not going to get shot, so I shouldn't be concerned about a trauma unit. If my wife and I have a car accident and we need to go for trauma, we, too, have to go outside the city of Chicago on the far downtown and west of downtown to go to a trauma unit, so it is not just about gunshots. When a trauma unit closes for adults, it closes for everybody.

Chairman RANGEL. And you are paying for the health care through taxes anyway. I assume you would exempt law enforcement?

Mr. REYNOLDS. In my original bill we made exceptions for law enforcement and the Army and other organizations that were certified security agencies.

Chairman RANGEL. Thanks for your testimony.

Mr. Hancock.

Mr. HANCOCK. Thank you, Mr. Chairman. I have several questions. I appreciate the position and I understand exactly where our colleague is coming from on this topic. I don't think any of us are immune to what is happening with firearms in this country. However, I think that when you start talking about an additional tax on firearms, you are going to see more firearms from an underground source that would be totally immune from the tax. I think that is one of the issues we will talk about.

As far as holding the manufacturers responsible, I think this is a play on words. The manufacturer is going to have to pass that along to whoever buys the guns. The manufacturers, except in a clear cut case of direct liability, will not be held responsible; and if you hold them too responsible, they ultimately go out of business which here again develops an underground economy of manufacturing weapons.

I understand this is an emotional issue, but I am also concerned about various statements. For instance, the testimony we heard from the American Medical Association states that when costs for ambulance service, physician services, rehabilitation and long-term care are included, total medical expenditures for firearm injuries reach an estimated $1 billion a year. I don't know what is your source, but your information is that it goes to $4 billion a year. Then we have another organization that estimates costs at $23 billion a year. They will be testifying later.

I think we are getting into an area here of mighty little excess emotion. I am also concerned about the trauma centers, but what about the inner cities and the big cities, what about the trauma centers in the rural areas? I don't know that we have as many gunshot victims in the rural areas, but we have a lot of automobile accidents which you mentioned. What about taxing cars with revenues earmarked to pay for automobile accidents? What about knives? What is the comparison between gunshot wounds and knife wounds? I think that when we are talking about what I consider a basic right guaranteed under the Constitution, which is the right to keep and bear arms, you are talking about taxing that right. I think we are getting into an area that is an infringement upon the second amendment, and I personally have always resisted any tax on firearms. In my judgment it violates the Constitution to attempt to tax a basic right under the Constitution.

I am very concerned about the situation that you are addressing, but I do not think that increasing the tax to 20 percent, 40 percent or 100 percent will solve the problem regarding the improper use of weapons. This problem is going to have to be approached through education. It is going to have to be done through strict law enforcement rather than tax increases and treatment for people if they become gunshot victims.

Here again, the number two function of government, in my opinion, is to protect the citizens' life, liberty and property against criminal acts of other people, not to pay their hospital bills after

somebody performs that criminal act. I think that is what we should be concerned about rather than an excise tax for the purpose of paying medical care. Thank you, Mr. Chairman.

Chairman RANGEL. Would the gentleman yield for the purpose of focusing a question to Mr. Reynolds? Under this constitutional right to bear arms, would automatic weapons be included under this constitutional right, in your opinion?

Mr. HANCOCK. Well, it depends on your definition of automatic weapons.

Chairman RANGEL. Weapons that you can push the trigger and have multiple expulsions.

Mr. HANCOCK. Frankly, I don't see any problem with a law-abiding citizen having any type of weapon as long as it is used in a legal and lawful way.

Chairman RANGEL. That would include mortars?

Mr. HANCOCK. I don't know why anybody would want one.

Chairman RANGEL. Well, I don't know why they would want an automatic weapon. Does that include artillery pieces?

Mr. HANCOCK. No, we are talking about handguns. We are talking about weapons that an individual can carry. We are not talking about 105 Howitzers.

Mr. REYNOLDS. May I respond? There were several issues in the form of questions that were raised, and I want to be as brief as possible, but I would like to address them because I think some of these issues are fundamental and really make up a fundamental difference in how one views the problem and how one deals with the problem. I don't think it is really emotional to want to do something about this because it is a problem that is destroying our society. That is a reality. That is happening all over this country.

Law-abiding citizens every single day get killed by guns from other law-abiding citizens until they kill them or by accident. We had a situation in Chicago where seven people working in a fast food restaurant were walked into a freezer and shot and killed. They were law-abiding citizens. Law-abiding citizens have something at stake here, too, as far as limiting this death and this mayhem that guns cause.

You mentioned cars and why don't we tax knives. There is a fundamental difference as to why we tax some things in the ways we do or why we hold people strictly liable for certain things they deal in. You can be held strictly liable if you drive tankers and they explode. It is not the driver's fault, but because you decided to be in such an inherently dangerous business, you can be held liable.

We do the same things with pesticides. Courts have held that you can be held strictly liable in that instance. What separates a car from a gun in this instance is the fact that cars are not made to kill people. Handguns and assault weapons are made for one purpose, to kill other human beings. That is it, and therefore in my opinion they are inherently dangerous, therefore they are in that category of inherently dangerous things that ought to be, in my opinion, eliminated and taxed along the way.

My legislation does not infringe upon a person's right to bear arms. I carefully crafted this legislation not to—so it would not go against the second amendment. The fact of the matter is, I will be very frank, if as a result of this legislation, if it were to pass and

manufacturers had to pay for the mayhem and the death to States because of their weapons and they decide to go out of business and not be involved in this, I wouldn't be upset about that if guns disappeared as a result of that.

Now, as far as law enforcement is concerned, the argument is often used that what we really need to do in this country is get tough, and therefore we can eliminate some of this crime. We won't have the problem with guns. How much tougher do we have to get in America? We kill more people in this country through the death penalty than any other industrialized country on the face of the Earth. Right now there are 24- and 25-year-olds serving life sentences in our prisons because they got caught with drugs on them. We are a tough, hard-nosed country. It still isn't changing anybody's mind about crime.

It isn't really curtailing crime, and it is not curtailing this gunshot mayhem. I hope I have addressed most of your concerns.

Chairman RANGEL. Mr. Payne.

Mr. PAYNE. Thank you very much, Mr. Chairman, and thank you, Mr. Reynolds, for your testimony. I just wanted to comment concerning my district, which is a predominantly rural district. A lot of my constituents are owners of rifles and shotguns and so forth because a lot of hunting goes on in our district, and it is my understanding that the excise tax on guns now is used for the purpose of promoting the wildlife in areas throughout our country, and this has been going on, I guess, since 1937 when this bill was first adopted.

I do think that while what you are trying to do certainly makes sense, it seems to me that in terms of the notion that we are looking at the universe of people who are responsible to pay this, there are a lot of people in this universe who are really not responsible for the victims who show up in our hospitals with gunshot wounds, and I did want to point that out because I think in districts such as ours where we have relatively few incidents such as that and quite a few number of people who are hunters and sportsmen, that they would see this not as an equitable way of financing propositions such as the one you put forth here.

Mr. REYNOLDS. First of all, new trust fund money would not affect any of the current wildlife money that goes to these organizations. In our country, because we have so much diversity and because we have so many different areas, there is always a shifting and a sharing of responsibility. Sometimes in this country if you live in a certain climate you get out of paying as much for maybe a Btu tax or for other kinds of gasoline taxes or heating oil taxes. You have to take on that burden because you live in the whole society. You don't just live in your State, and are responsible for just your State.

People who live in your area come to the city of Chicago on occasion, I am sure, and they go to New York City and they go to L.A. and Detroit and Atlanta. This would serve to help them as well if we could have a better trauma system. If they are driving through the town or they get shot by accident or someone shoots them on purpose and they can't go to a trauma unit, all of a sudden it is not going to matter whether or not there are many incidents like this in a particular State. All that is going to matter is that one

particular instance when they couldn't get treatment because there was no trauma unit available.

Every day in Chicago people die, simply because they can't get to a trauma unit quickly enough, and I am trying to figure out a way to shift this responsibility to these manufacturers. They make guns without any kind of moral obligation to be concerned about what happens, and you never hear any of these organizations getting involved in inner cities to try to curtail the violence through programs, through education or anything like that. They just make the gun and walk away from it, so I am trying to do something about that.

Mr. PAYNE. I understand that, and as I say, I simply wanted to point out that because of that same diversity that you had mentioned that we are not dealing simply with a universe of people who are creating this problem, but people in this universe who would be affected who are supportive now of these excise taxes because of a use of the funds who may not be supportive of excise taxes if they are used for various different purposes, but I thank the gentleman.

Mr. REYNOLDS. Mr. Payne, I appreciate your concern, and with all due respect we never, a lot of us in this country don't like the way our tax money is used when we pay our income tax. We don't really have a say so, a lot of times, on how it is going to be used. We pay our taxes and we allow the government to sort of make decisions, and we don't always agree with them, and in this instance I am sure some people might not like it, but overall I think it would be better for our society.

Chairman RANGEL. Mr. Kopetski.

Mr. KOPETSKI. Thank you, Mr. Chairman. I commend my colleague for trying to address the issue of health care and trauma centers in the urban areas. I should point out, though, that many gun—most gun clubs in America, and including the NRA organization and other gun organizations sponsor gun safety programs and wise use of weapons and in fact, they are known for that, especially in places out West.

Are you aware that your tax would apply to licensed firearm dealers only? That it does not apply nor could it readily be applied to private transactions of sales of guns, including flea markets?

Mr. REYNOLDS. Yes, I am aware of that.

Mr. KOPETSKI. What percent of people that go to a licensed firearm dealer do you think obtain those guns for lawful purposes and use them for lawful pumps?

Mr. REYNOLDS. I am not aware of what percent do. I think that——

Mr. KOPETSKI. Do you think it is over 90 percent?

Mr. REYNOLDS. A gun that is ended up for legal purposes and ends up injuring someone, we still have to take care of that person, whether or not the person intended for that person to be injured or not. We have uninsured folks who have to go then be taken care of.

Mr. KOPETSKI. Most people buy guns and use them for lawful purposes. They don't go shoot another person or rob a store. Do you think that is a fair statement?

Mr. REYNOLDS. I would imagine, but I don't know, unless you have some scientific empirical study that has been done on that, I would like to see that, but I don't really know that to be the case. To address an earlier point, Mr. Kopetski, about education, they might do that out West, and I am sure they do in Oregon and in California and other places. In the inner city of Chicago, I don't ever, as long as I have been living in the inner city of Chicago, which is all my life, I don't ever remember seeing the NRA do anything positive at all in my community, nothing at all.

Mr. KOPETSKI. And so what you are suggesting is that the problem is in the big cities, such as Chicago?

Mr. REYNOLDS. I am suggesting that I have not seen the NRA do anything positive in my community.

Mr. KOPETSKI. Well, the reason you are bringing this legislation forward is because you see a problem in Chicago?

Mr. REYNOLDS. I see a problem in Chicago, but I see it nationally. I see it in Los Angeles, I see it in other parts of this country as well.

Mr. KOPETSKI. I want to get to the tax policy of this. What you are suggesting in terms of tax policy is that hunters, people who lawfully use, buy rifles or handguns, should pay for the health care of people in urban areas?

Mr. REYNOLDS. If we have a national health plan.

Mr. KOPETSKI. We are not talking about the national health plan.

Mr. REYNOLDS. I know you are not, but your analogy is this: You are suggesting from your questioning that somehow because you don't live in an urban area, someone else doesn't live in an urban area, then they shouldn't be responsible for paying for folks in urban areas. But if we have a national health plan, we are all going to be responsible for paying into the system or employers are going to be responsible for paying into the system whether they live in urban areas or rural areas. We are all going to have to share the burden.

Mr. KOPETSKI. But the purpose of your bill is not national health care. The purpose of your bill is to fund trauma centers related to guns, so that is really a separate issue. What you are suggesting is that the people of the West, for example, pay for trauma centers in the city of Chicago?

Mr. REYNOLDS. I am suggesting——

Mr. KOPETSKI. Or the people in the rural area of Illinois pay for trauma centers in downtown Chicago, that is the tax policy? Since most firearms are purchased and lawfully used by rural residents.

Mr. REYNOLDS. Well, you know, the fact of the matter is, I am suggesting that they help pay for trauma units, if it is on the west coast in Portland, if it is in Los Angeles in California or San Francisco, wherever there is a problem where a hospital has had to close a trauma unit as a result of not being able to treat uninsured victims, gunshot victims in particular, they ought to be able to get some money from this fund to do that.

Mr. KOPETSKI. Well, is it——

Mr. REYNOLDS. As a policy, I don't have a problem with that.

Mr. KOPETSKI. How can I ask the people of downtown Chicago to help pay for the health care of people in Salem, Oreg.?

Mr. REYNOLDS. The same way we ask the people of downtown Chicago to help their tax dollars go to the Tennessee dam plan or to——

Mr. KOPETSKI. No, no, you see what I am saying, the money is going to flow one way, to Chicago from my State, and what I am asking you is——

Mr. REYNOLDS. Moneys flow one way from your State on lots of different things as far as the tax policy is concerned.

Mr. KOPETSKI. I am trying to stop that.

Mr. REYNOLDS. Well, the fact of the matter is that currently lots of money flows from your State one way for lots of programs that don't come back to Oregon, defense programs that don't come back to Oregon, correct?

Mr. KOPETSKI. But the Oregon hunter is not causing the problem in downtown Chicago. Why not very simply have the city of Chicago increase their taxes to fund the trauma center?

Mr. REYNOLDS. That is something that local municipalities are strained, as you know, for city services and because of the last two administrations, they are doing their best to tax people to help the infrastructure and keep the city afloat as far as the working of the city every day. They are already strained enough from these kinds of problems they have had over the last two decades.

Mr. KOPETSKI. So because the city of Chicago cannot adequately deal with the fact that it is a violent city, and can't take care of itself, it wants to tax Oregonians to pay for their trauma center.

Mr. REYNOLDS. Oregonians are going to benefit from this, as well.

Mr. KOPETSKI. How?

Mr. REYNOLDS. In Portland there may be a situation where a trauma unit is in trouble because it can't afford to pay for uninsured victims. It is not always just uninsured.

Mr. KOPETSKI. We have trauma centers, we fund them.

Mr. REYNOLDS. It is not always uninsured gunshot victims, but once again there is nothing unusual about this legislation that would be different than what we are doing right now. As you alluded to earlier, and I think admitted that taxes flow from Oregon all the time for things that are outside of Oregon, all the time. This is nothing—people in Oregon pay for things in Massachusetts and people in Illinois pay for things in Mississippi. That is not unusual.

The question is do we care about our society and can we live on an island in Oregon and say that is not our problem, so let's not worry about it until somebody gets off a plane in Chicago and gets shot from Oregon and can't find a trauma unit to go to, then all of a sudden there is a big article back in the Oregonian talking about the horrible city and how no one can be safe because there wasn't a trauma unit, and then we are connected in this whole thing.

Mr. KOPETSKI. Well, I don't understand why it is OK—you worry about the Portland person who gets mugged or shot in Chicago, but it is not OK if a Chicago resident pays for Oregon's health care.

Mr. REYNOLDS. Chicago residents and residents all over this country. I think that Chicago residents and members of my district would be more than willing to pay into a system of health care that would cover people in Oregon as well.

Mr. KOPETSKI. They are not willing to pay for their own, why would they be willing to pay for Oregon?

Mr. REYNOLDS. They are willing to pay for their own.

Mr. KOPETSKI. No, they are not. You said they are shutting them down. They are shutting them down all over the city. They are not willing to pay for it.

Mr. REYNOLDS. The hospitals are private hospitals, not the city of Chicago. The private hospitals are shutting down and saying they can no longer afford private industry saying they can no longer afford to pay for uninsured gunshot victims. The city of Chicago and the State of Illinois pay several hundreds of thousands of dollars every year for uninsured victims in the city currently.

Now, we are talking about adult trauma centers. There are currently juvenile trauma centers that are currently open that the city—I mean that these private industries are paying for right now.

Mr. KOPETSKI. Mr. Chairman, my final question is it is my understanding that the courts have ruled that gun manufacturers are not strictly liable for accidents caused by—or a crime committed by a user of the gun. Is that correct?

Mr. REYNOLDS. In the court of Maryland in the court of law not long ago the court ruled—no, that is not correct. In Maryland, for example, the court recently ruled that the gun manufacturer in a Saturday night special case ought to have known what the gun was being made for, to kill people, and therefore was held strictly liable in that case.

Mr. KOPETSKI. And the case is on appeal, but it was a Saturday night special, not a——

Mr. REYNOLDS. But the court did rule against them, and say they ought to have known.

Mr. HANCOCK. Will the gentleman yield? It has been said several times that guns are designed to kill people. That isn't necessarily correct. Some people buy guns to keep from being killed, as self-defense. A very few people buy guns with the express purpose of going and killing somebody. So guns are designed to kill, but they are also designed to provide that person with defense to keep from being killed also.

Mr. REYNOLDS. You said two things. You said that guns aren't made to kill people, but people buy guns——

Mr. HANCOCK. I said they are designed to kill people, there is no question about it; but they are designed as a defense, as are our military weapons which are designed to kill people to defend the United States. That is why we design them, but they are designed to kill people. Our whole military is designed to kill people. Their number one function is to kill people, but it is to provide for the national defense. The right to keep and bear arms is to provide for the national defense or the individual defense. Do you own weapons?

Mr. REYNOLDS. I do not.

Mr. HANCOCK. Well, I do, but I have never bought one with the idea of going out and shooting somebody.

Mr. REYNOLDS. Well, the fact of the matter is that it becomes irrelevant when you have a case like we just had recently in the South where a young exchange student went to the door and knocked on someone's door and did not quite understand the sort

of local jargon and was shot like an animal in the name of self-defense, and the court ruled in that case that the law-abiding citizen was justified in doing what he did.

Mr. HANCOCK. There is no way for us to sit here and say that this person, having used the gun wasn't extremely upset about the fact that somebody was there in a costume. He didn't have any idea who he was; and he obviously would not follow orders and he had no way to know that. But that is a different situation. I agree, guns are designed to kill, but they are primarily bought not to kill people. They are bought to provide defense for the person that owns the gun.

Mr. REYNOLDS. Mr. Hancock, it is a false sense of security. The New England Journal of Medicine has reported that if you buy a gun to protect yourself in your home, you are 43 times more likely to have that gun used on you, a member of your family or a close family friend.

Mr. HANCOCK. Well, as under the second amendment of the Constitution, I will accept that responsibility.

Mr. REYNOLDS. Well, the problem with accepting that responsibility, and that is your right, is that our society is being destroyed like no other society in the world because of our insanity with guns, and I am trying to do something about this problem without relying on the established way of doing things.

Mr. HANCOCK. I appreciate it, and I know that you are as sincere as you can possibly be; but this is just a major disagreement that we have, and I respect you for taking on an issue that you know is not going to be particularly popular anyplace except maybe in the urban cities. It isn't going to be popular at all in most of the United States, and I congratulate you for taking on that issue.

Mr. REYNOLDS. May I just make a quick—this is an issue that is a very difficult issue, and we in this body, I believe, have a responsibility to the citizens in this country. I believe that people who disagree with my position are very sincere. They are very caring, and they care just as much about America as I do, but I am trying my very, very best to get to a solution to this problem. I live in that 40-people-a-day situation getting shot. I know people like my wife who is 30 years old and is afraid to go outside by herself any day, any time 7 days a week to just sit back and say we have a constitutional right to have guns, it is a right of everybody to say that, but I am trying to do something about this problem, and I really appreciate the committee taking the time to listen to what I have to say.

Chairman RANGEL. Well, let me thank you for focusing attention on a very, very serious problem that our Nation is having and we will see how much support we can get. Thank you very much.

Mr. REYNOLDS. Thank you, Mr. Chairman.

Chairman RANGEL. The written testimonies of Congresspersons Stark, Durbin, and Meek will be entered into the record.

[The prepared statements and attachments follow:]

TESTIMONY OF CONGRESSMAN PETE STARK
BEFORE THE
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON SELECT REVENUE MEASURES

June 29, 1993

Mr. Chairman, Members of the Committee: I want to thank you for the opportunity to appear before you and provide testimony on two legislative items under consideration, a tax on unsafe needles and support of charitable risk pools.

Anti-Needlestick Legislation

H.R. 1304, legislation Chairman Rangel and I introduced earlier this year, is designed to reduce the risks to health care workers from accidental needlesticks. H.R. 1304 will ensure that the necessary tools -- better information and better medical devices -- are made available to our front-line health care workers in order to reduce the injury and death that has resulted from needlesticks.

I would like to enter into the record a list of some of the individuals, organizations and corporations in support of this legislation. Support for H.R. 1304 has come from all quarters: inventors and manufacturers -- well over a dozen corporations are listed in support -- researchers, and most importantly consumers. They share the opinion that this legislation will facilitate the incorporation of safer needle devices into the workplace.

It is estimated that last year alone there were 800,000 accidental needlesticks in hospital settings from needle-bearing devices. Accidental needlesticks produce the single greatest risk of blood exposure to the HIV virus for health care workers. According to a study by the Centers for Disease Control, 80% of the blood exposures to HIV in the health care setting were caused by needlestick injuries. The CDC has documented at least 36 cases of HIV infection as a result of an accidental needlestick. Infection with the hepatitis B virus and other infectious agents are also transmitted through needlesticks.

Nurses have suffered the greatest number and the greatest harm from accidental needlesticks. Seventeen nurses are known to have contracted HIV from accidental needlesticks. For these reasons, it is not surprising to note that the 200,000-member American Nurses Association, the American Association of Occupational Health Nurses and the Association of Operating Room Nurses have strongly endorsed H.R. 1304.

But nurses are by no means the only ones at risk from accidental needlesticks. Clinical laboratory personnel, fire fighters, patient attendants, housekeeping personnel, and family care-givers are some of the others at tremendous risk from the split second jab of a contaminated needle. This is why the Service Employees International Union has been working for so many years to achieve the measures contained in H.R. 1304, and why they support this legislation. This is why the American Society for Medical Technology representing 20,000 plus non-physician laboratory personnel, the International Association of Firefighters, and the Hospital and Health Care Workers Union all assisted in the drafting of this legislation and have issued statements of support for H.R. 1304.

Over 800,00 needlesticks occur each year. At a cost of $600 for testing and counseling for each stick, the financial burden is tremendous. The psychological toll is even greater.

Imagine what someone must go through when accidentally pricked with a used needle device. Tests must be conducted to determine if the blood on the device contained an infectious agent. If so, the health care worker must undergo tests to see if they have been infected. If the blood contained the HIV virus, one could

not be sure for up to three months whether an infection occurred. With the tremendous number of needlesticks that occur, this process is repeated literally thousands of times each day.

Better information and better devices are the key to reducing injuries from needlesticks. In H.R. 1304, it is recognized that today the greatest tool we can put in the hands of nurses and other health care workers is information. There are dozens and dozens of so-called "safer" needle products on the market and in development. Each of these contains a manufacturer's claim to the efficacy of the device. Some in fact may be safer; others may not. If injuries are to be reduced, better information must be collected as to which medical devices will actually reduce the number of accidental needlesticks.

To compile the information needed, H.R. 1304 requires that the Food and Drug Administration develop safety performance standards for needle devices and subsequently assess the devices to determine whether they have been shown to reduce accidental needlesticks. The FDA is instructed to draw upon the experiences in the private sector with the development of performance criteria and with product assessment. With the assessments in hand, the purchasers and the consumers will then have the information necessary to make their purchase and use decisions. Because these assessments have not yet been conducted to the extent one would have liked, a period of three years is provided for these assessments to take place.

Once this information is in hand, we must ensure that it is used -- we must ensure that the better devices get into the workplace. Health care institutions must be encouraged to substitute existing needlestick products with products proven to be safer. To this end, a tax will be imposed three years out -- in 1997 -- on needle devices not found to reduce the risk of accidental needlesticks. (The tax would be 10 cents per device and would only apply upon sale of needle-bearing medical devices to those with Medicare provider numbers. Sales of needles for personal use would not be taxed.)

I'd like to briefly explain how I anticipate the assessment of needle devices to occur. As stated, the FDA would be required to develop safety performance standards. Items such as whether they can be operated with one hand, whether they provide passive protection, whether they prevent reuse, and other considerations deemed appropriate would be listed. Over the first three years, as data becomes available on various products, the devices would be measured against the performance criteria. By 1996, the FDA would make a determination as to the level of performance considered acceptable (i.e. how many of the criteria must be met) for a product to be considered "safer." Due to the limitations of the technology or the cost of production, products might not initially achieve universal compliance with the safety performance standards. Nonetheless, a determination will be made as to what minimum level of performance would be acceptable.

In subsequent years, the level of performance considered acceptable would be raised as technologies improved. To provide purchasers and consumers with the most accurate information possible, product assessments would be updated at least annually by the government.

This approach was chosen after consultations with numerous individuals and groups that manufacture and use medical devices. Many manufacturers and union representatives have been frustrated in their attempts to get safer needle products into the hands of clinicians. Management of health care institutions often respond that the "safer" products are too expensive. A typical straight needle device used today costs a few cents. Needles with the most promising safety features -- while expected to be priced somewhere in the area of 13 to 16 cents when levels of production are sufficiently high -- currently cost several

times the amount of standard needles. A hospital purchasing clerk, looking only to the price of the item, sees a significant price differential. H.R. 1304 would eliminate much of the price differential so that consideration is also given to safety of these products, not just to the price.

If the supply clerk were able to see the entire cost associated with the use of a needle device (the $600 per needlestick for testing and counseling, the trauma of uncertainty, and the loss of health and life), the balance would be more than tipped in the favor of safer products.

There has been some discussion as to whether a tax is an appropriate approach. Mr. Chairman, if I could, I'd ban all needle devices today that didn't provide our front-line health care workers with the best protection available. Forget about imposing a ten cent tax; ban all needle-bearing devices from the workplace that don't provide an adequate level of protection. The problem is that we do not know today which products we would ban and which we would use. Claims are made by manufacturers, and guesses can be offered by those purchasing the products as to the efficacy of the devices, but adequate data on which products actually result in reduced needlesticks has not been compiled.

This legislation ensures that coordinated assessments of these products will take place and that performance as well as cost will be considered in purchase decisions. This legislation sends a clear signal to government and private institutions alike that the status quo is not acceptable. The challenge given to federal agencies such as the FDA is that assessments of product performance must be completed by January 1, 1997. Likewise, this legislation gives health care institutions a target date to incorporate safer needle-bearing devices.

For the sake of the thousands of health care workers on the front-lines of care-giving, for the fire fighters, sanitation workers and laboratory personnel who are at risk from needlesticks, I wish I could tell them that safer medical devices will be available when they report to work tomorrow. Sadly enough, I can't. But through this legislation, by the continued work of government scientists and regulators, with the continued inventive energies of private sector researchers and manufacturers, and through the persistence of union members and representatives to get these devices into the hands of the health care professionals, I believe the workplace will become a much safer place.

Charitable Risk Pools

The second proposal I would like to call your attention to would allow charities to pool their normal liability risks in a 501(c)(3) organization. These charitable risk pools would provide charitable organizations with a steady source of affordable liability insurance and educate members of the risk pool in ways to minimize their liability risks.

In order to qualify for nonprofit status, the risk pool would have to be composed entirely of 501(c)(3) organizations, and must receive its start-up capital from sources unrelated to the charitable organizations insured by the risk pool.

The need to clarify the tax exempt status of charitable risk pools was brought to my attention by an organization called the Nonprofits' Insurance Alliance of California (NIAC) but the proposal would cover risk pools formed by nonprofits in other states such as Illinois, Michigan, Arizona and Maryland that allow charitable risk pools.

NIAC has almost 800 members, the bulk of them are very small charities. The median annual budget size is $170,000. NIAC members include day care centers, inner city substance abuse programs and HIV services, homes for severely disturbed adolescents, and centers for children with cancer.

In short, NIAC members are not ideal candidates for low cost commercial insurance coverage.

However, NIAC has been able to provide below cost coverage for these nonprofit members because all of NIAC's implementation costs and start up capital---$1,600,000 to date--comes from independent private and community foundations such as the Ford Foundation and the Packard Foundation. Foundations provided this low cost capital because they saw charitable risk pools as a way to fill a gap where commercial insurers were not providing an adequate or affordable coverage to nonprofits.

This capital from nonprofit sources unrelated to the risk pool members allows NIAC to pass savings of approximately 30% below commercial rates to the risk pool members. This saved NIAC members over $2 million in 1993, reducing overhead so that charities have more funds available to carry out their charitable mission.

It is questionable whether charitable risk pools such as NIAC can be a 501(c)(3) under current law. However, the Treasury Department testified on June 22, 1993 that "the Administration would not oppose a provision under which a charitable risk pool could qualify as a section 501(c)(3) organization, notwithstanding section 501(m), provided that the charitable risk pool receives a substantial amount of contributions from non-members that it uses to subsidize the coverage provided to members."

Mr. Chairman, I plan to introduce legislation today that allows nonprofits to pool their risks and meets the concerns of Treasury that the subsidized capital be used to reduce the costs of members.

Thank you for your consideration of these two issues.

Supporters of H.R. 1304:
Anti-Needlestick Legislation

Consumers

American Nurses Association
International Association of Firefighters
American Association of Occupational Health Nurses
Service Employees International Union
American Society for Medical Technology
Registered Nurses Professional Association
Local 250, Hospital and Health Care Workers Union
American Society for Gastrointestinal Endoscopy
The Association of Operating Room Nurses, Inc.

Manufacturers

Safe Mate Health Technology Systems, Inc., Lexington, Kentucky
Square One Medical, Camarillo, California
Philips Medical Group, Cary, North Carolina
Child Safety Sciences, Inc., Elkhart, Indiana
Safety Systems, Ann Arbor, Michigan
Medico Diagnostic Products, San Jose, California
Bioject Inc., Portland, Oregon
Gabbard Murray Gabbard, Inc., Mount Juliet, Tennessee
Hake Instruments, Inc., Grand Islands, Nebraska
Med-Design, Inc., San Jacinto, California
Xerion Corp., Rapid City, South Dakota
U.S. Medical Instruments, Inc., San Diego, California
R. Ward Basnight Corp., Cary, North Carolina
Injectimed, Ventura, California
American Medical Finance Corp., Q-Care Division, Marietta, Georgia
Smiths Industries Medical Systems, Dublin, New Hampshire
Cambridge Multi-Draw, Inc., Cambridge, Massachusetts

Regulatory Agencies

South Carolina Department of Mental Retardation

RICHARD J. DURBIN
20TH DISTRICT, ILLINOIS

AT LARGE WHIP

COMMITTEE ON APPROPRIATIONS
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SUBCOMMITTEE ON TRANSPORTATION
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TESTIMONY OF
THE HONORABLE RICHARD J. DURBIN
BEFORE THE
SUBCOMMITTEE ON SELECT REVENUE MEASURES
COMMITTEE ON WAYS AND MEANS

JUNE 29, 1993

Mr. Chairman, I would like to thank you for this opportunity to testify on behalf of my proposed legislation to encourage organ donation.

I have proposed that we conduct a cost-effective public education campaign about this issue by inserting organ donation information in next year's mailing of income tax refund checks. It is my hope that this proposal can be included in legislation this committee may send to the House floor later this year.

THE SHORTAGE OF ORGAN DONORS

Governor Robert Casey's recent organ transplant operation has attracted considerable media attention. But what made his situation remarkable was not the fact that he survived. Organ transplantation is an American medical success story. What was once a futuristic, daring approach to life-threatening diseases is now an accepted part of the practice of medicine. Even double-organ transplant recipients like Governor Casey have a good chance of survival.

What made Governor Casey's case remarkable was how quickly he received the organs he needed. More than 31,000 Americans are on the waiting list for organ transplants, including nearly 1,500 children. Governor Casey was sent to the head of the waiting list because he needed two organs, a condition that is given priority over cases where only one organ is needed. But for many of the people who are waiting, the wait is long and arduous -- and even deadly.

The most common tragedy in organ transplantation is not the patient who receives a transplant and dies, but the patient who has to wait too long for an organ and dies before a suitable organ can be found. The number of people who need an organ transplant greatly exceeds the number of available organs, and the waiting list is growing.

When I first proposed this legislation in 1990, the waiting list was around 20,000 persons. In less than three years, it has jumped to more than 31,000 persons, and a new name is added every 20 minutes. Meanwhile, 2,500 people on the waiting list die each year because their bodies simply cannot wait any longer for the needed transplant. The list also includes more than 23,000 people who must survive on kidney dialysis while they wait.

Organ transplants only happen because a grieving family authorizes the transplanting of their loved one's organs. It can be difficult to cope with

death, particularly when a car crash or accident causes someone to die unexpectedly due to massive brain injuries that leave the body relatively untouched. However, something good can come from this kind of tragedy; organ donation can give another human being a new chance at life. In fact, many times, an organ donor can give several other human beings a new chance at life, because about 25 different types of organs and tissues can now be transplanted.

It is particularly frustrating, therefore, that many opportunities to utilize organs are lost -- and many people on the waiting list die -- because no one authorizes the donation of the organs. While around 4,500 donors supply more than 16,000 transplants each year, this represents only about one-third of the potential donors. The other potentially life-saving transplants never occur, often because of people's hesitance to authorize organ donation either for themselves or for a family member who has died.

THE ORGAN DONATION INSERT CARD PROPOSAL

My legislation would direct the Secretary of the Treasury to enclose with each income tax refund check mailed next year an insert card that encourages organ donation. The insert would include a detachable organ donor card. It would also include a message urging recipients to:

- o sign and carry the card,
- o tell their families about their willingness to be an organ donor if the occasion arises, and
- o encourage their family members to request or authorize organ donation if the occasion arises.

The weak link in our nation's organ donation efforts is the link to the family. As a general rule, organ donation will not occur unless the family authorizes it, regardless of whether a potential donor signed an organ donor card or has a box checked on their driver's license. This means it is essential that people who wish to donate organs inform their family members of their wishes. If the family members can recall that their loved one talked to them about the matter, they are more likely to authorize the donation.

My legislation addresses this weak link by emphasizing the need to discuss the matter with family members. Organ donation organizations have particularly appreciated this aspect of the legislation. Here are some of their comments:

> Your proposed legislation would not only serve to take the necessary first step: ask people to sign an organ donor card, but could also serve as a catalyst to prompt discussion of one's wishes with family members, thereby reducing the instance of family refusal to donate a loved-one's organs. [Amanda W. Culbertson, Executive Director, International Society for Heart and Lung Transplantation]

> [M]any organs are lost because the family did not know of their loved one's wishes. With passage of your bill, individuals receiving tax [refunds] will be reminded, at home, in the presence of their family, that they need to speak out rather than simply silently agreeing with the concept of organ donation. [Gene A. Pierce, Executive Director, United Network for Organ Sharing]

> We are pleased that the information would state more than simply signing a donor card; of even greater importance is that the individual make his/her wishes known to family members that would be

asked to sign the consent forms. [Thomas Armata, Executive Director, South-Eastern Organ Procurement Foundation]

We believe this process to be very important in helping the immediate next of kin make a decision at the time of death of their loved one. [Stephen D. Haid, President, Association of Organ Procurement Organizations]

If families will authorize, and even press for, the donation of organs, the number of organs that are made available could increase substantially.

When I first proposed this legislation, the Financial Management Service of the Treasury Department advised me that enclosing an insert card with every income tax refund check would reach around 80 million households with this important message. They indicated that designing, printing, and including the cards with refund checks would cost approximately $500,000.

The population that would receive these cards is very appropriate for an organ donation appeal. For most transplants, it is best if the organ donor is between the ages of 15 and 65. The people who receive income tax refunds tend to be adults rather than children, and younger than retirement age. They tend to be in the prime ages for organ donation themselves, and are often the next-of-kin for others who are in the prime ages for organ donation. Therefore, this appeal will reach a very appropriate group in a highly cost-effective way.

Furthermore, inserting this appeal with IRS refund checks poses no logistical problems for the Treasury Department. They have been enclosing insert cards with refund checks for years. This year's refund checks were accompanied by an appeal to buy a special Bill of Rights commemorative coin. In past years, insert cards have advertised similar appeals -- for example, for a Mount Rushmore anniversary coin and an Eisenhower centennial coin. While the content of the insert card would be different next year under my proposal, the process of sending out income tax refund checks wouldn't change.

POSITIVE REACTIONS

I have been gratified by the response this proposal has received. When I introduced legislation on the subject in the last Congress, 58 of our colleagues cosponsored the measure, but we never had an opportunity to move it to the House floor. This year, while I have not formally reintroduced the bill, I have found continued support wherever it has been discussed.

The proposal has also been well-received in the medical and transplant recipient communities. More than a dozen organizations have endorsed the measure and offered to help, including the United Network for Organ Sharing, the American Nurses Association, the American Society of Transplant Physicians, the American Society of Transplant Surgeons, the Association of Organ Procurement Organizations, the American Heart Association, the National Kidney Foundation, and the Transplant Recipients International Organization. I have attached to my statement a complete list of endorsing groups, a sample of their letters of support, and a summary of my legislation.

Mr. Chairman, by increasing public awareness and encouraging family discussion about organ donation, I believe this legislation could increase the number of donors and reduce the number of people who die while waiting for transplants. I hope this committee will act favorably on the proposal and guide it through the legislative process until it is signed into law.

6/93

Rep. Richard J. Durbin's Organ Donation Insert Card Bill

What the Proposed Legislation Does

This legislation directs the Secretary of the Treasury to enclose with each income tax refund check mailed between February 1 and June 30 of next year an insert card that encourages organ donation.

The insert would include a detachable organ donor card. It would also include a message urging recipients to sign and carry the card, tell their families about their willingness to be an organ donor if the occasion arises, and encourage their family members to request or authorize organ donation if the occasion arises.

The actual text of the card would be developed by the Secretary of Health and Human Services, after consultation with organizations promoting organ donation. (An alternate version of the bill would reduce the jurisdictional complexity of the bill by directing the Secretary of the Treasury to develop the text of the card after consultation with the Secretary of Health and Human Services and organizations promoting organ donation.)

Why the Legislation Is Needed

The most common tragedy in organ transplantation is not the patient who receives a transplant and dies, but the patient who has to wait too long and dies before a suitable organ can be found. The demand for organs greatly exceeds the supply. More than 31,000 people are now waiting for an organ transplant, including nearly 1,500 children and more than 23,000 people who must have kidney dialysis while they wait for a kidney to become available. Approximately 2,500 people on the waiting list die each year before receiving a transplant. Meanwhile, another person is added to the list every 20 minutes.

If an insert card is provided with every income tax refund check, around 80 million households will be reached. According to the Financial Management Service of the Treasury Department, designing, printing, and including the cards with refund checks would cost approximately $500,000. Inserting this appeal with IRS refund checks poses no logistical problems for the Treasury Department; in recent years, refund checks have been accompanied by insert cards offering special commemorative coins for sale.

The population that would receive these cards is very appropriate for an organ donation appeal. For most transplants, it is best if the organ donor is between the ages of 15 and 65. The people who receive income tax refunds tend to be adults rather than children, and younger than retirement age. They tend to be in the prime ages for organ donation themselves, and are often the next-of-kin for others who are in the prime ages for organ donation.

Many opportunities for organ donation are lost due to people's hesitance to authorize organ donation either for themselves or their family members who die. Even a signed donor card does not ensure a donation, because the next-of-kin must authorize the donation. By encouraging organ donation and emphasizing the importance of family discussion, this legislation could expand the pool of potential donors, increase the likelihood that families will authorize donation for their loved ones, and reduce the number of people who die while waiting for transplants.

Organizations Supporting

Rep. Richard J. Durbin's Organ Donation Insert Card Bill

American Association of Critical-Care Nurses
American Association of Kidney Patients
American Association of Transplant Surgeons
American Heart Association
American Nurses Association
American Society of Transplant Physicians
American Society of Transplant Surgeons
Association of Organ Procurement Organizations
Children's Organ Transplant Association
International Society for Heart and Lung Transplantation
Michigan Transplant Institute
Mid-Atlantic Renal Coalition
National Kidney Foundation
South-Eastern Organ Procurement Foundation
Transplant Recipients International Organization
United Network for Organ Sharing (UNOS)

American Nurses Association
600 Maryland Avenue SW, Suite 100 West, Washington, DC 20024-2571
202-554 4444 • Fax 202-554-2262

Virginia Trotter Betts, JD, MSN, RN
President

Barbara K. Redman, PhD, RN, FAAN
Executive Director

June 23, 1993

Honorable Richard J. Durbin
U.S. House of Representative
Washington, D.C. 20515

Dear Congressman Durbin:

On behalf of the American Nurses Association (ANA) and its 53 state and territorial nurses associations, I am writing to express our support for your proposed legislation to require every income tax refund check to include an insert card that encourages organ donation.

As frontline providers of health care, nurses are acutely aware that the demand for tissues and organs greatly exceeds the supply and support the development of educational strategies on the benefits of organ donation. Your proposal is a low-cost effective means of increasing the public's awareness of the need for organ and tissue donation. In addition, the section in your proposal which provides for the inclusion of a detachable organ donor card will enable potential donors to participate immediately in the program. This legislation could be extremely helpful in increasing the number of donors and decreasing the number of people who die while waiting for transplants.

We appreciate your commitment to public education for organ donation and look forward to working with you to achieve enactment of your proposal at the earliest possible date.

Sincerely,

Virginia Trotter Betts/jc

Virginia Trotter Betts, JD, MSN, RN
President

grel/mwv/durbin
deh:6-23-93

INTERNATIONAL SOCIETY FOR HEART AND LUNG TRANSPLANTATION

June 16, 1993
476/630

Representative Richard J. Durbin
20th District, Illinois
2463 Rayburn Building
Washington, DC 20515

Dear Representative Durbin:

The International Society for Heart and Lung Transplantation offers its strong support for your proposed legislation to enclose with each income tax refund check an insert card that encourages organ donation. Many people who have not signed an organ donor card have not done so simply because they do not know enough about organ donation, or because they have never been asked to sign an organ donor card. Education about organ donation is needed, and the potential benefits of such education are significant in terms of the number of lives that could be saved if more donor organs were available.

Your proposed legislation would not only serve to take the necessary first step: ask people to sign an organ donor card, but could also serve as a catalyst to prompt discussion of one's wishes with family members, thereby reducing the instance of family refusal to donate a loved-one's organs.

The Society represents over 1500 cardiothoracic surgeons and physicians, as well as nurses, transplant coordinators, immunologists, and others involved in heart and lung transplantation. Your efforts to support and encourage organ transplantation are appreciated by our members.

Sincerely,

Amanda W. Culbertson
Executive Director

AWC/lyma

435 North Michigan Avenue Suite 1717 Chicago, Illinois 60611-4067 Phone: 312-644-0828 Fax: 312-644-8557

UNOS

1100 Boulders Parkway, Suite 500
Post Office Box 13770
Richmond, Virginia 23225-8770

Telephone (804) 330-8500
FAX (804) 330-8517

June 16, 1993

Rep. Richard J. Durbin
2463 Rayburn HOB
Washington, DC 20515-1320

Dear Rep. Durbin:

UNOS -- the United Network for Organ Sharing -- is encouraged and heartened by your effort to increase the number of organ donors in this country through insertion of a donor card and general information leaflet with every 1994 federal income tax refund check.

Passage of your organ donor insert bill would be a tremendous boon to patients relying on the generosity of strangers to donate organs to save their lives. Currently more than 31,000 patients are waiting for organ transplants in the United States. The tragedy of the situation is made all the more clear when one realizes that in all of 1992, only 16,503 transplants were performed. Demand continues to rise at a pace far exceeding the supply of organs.

Although polls indicate the majority of Americans have heard of organ transplantation and believe it is a worthy cause, few actually remember to sign a donor card or inform their family of their desire to donate. Subsequently, many organs are lost because the family did not know of their loved one's wishes. With passage of your bill, individuals receiving tax returns will be reminded, at home, in the presence of their family, that they need to speak out rather than simply silently agreeing with the concept of organ donation.

Not only is your bill noteworthy in its effort to save lives, the dissemination of donor material through the Internal Revenue Service could not be more appropriate in that it targets individuals of the optimum age for donation -- those between ages 18 and 65.

UNOS applauds your effort to introduce an organ donor insert bill and will do everything it can to assist in its passage.

Yours very truly,

Gene A. Pierce
Executive Director

72-311 O - 94 - 2

AOPO
Association of
Organ Procurement
Organizations

June 18, 1993

Congressman Richard J. Durbin
2463 Rayburn House Office Building
Washington, D.C. 20515-1320
ATTN: Heather

Dear Congressman Durbin:

On behalf of the Association of Organ Procurement Organizations, I am pleased to support your proposed legislation regarding "organ donation insert card." As you know, there continues to be a severe shortage of available organs for those in need of transplantation. By including information and donor cards in income tax refund envelopes, a large number of people will be reached. This effort to increase public awareness about organ donation could result in an increased number of donors. It is also our understanding that the information in the mailing would include a message urging individuals to tell their family members about their willingness to be an organ donor if the occasion arises. We believe this process to be very important in helping the immediate next of kin make a decision at the time of death of their loved one.

Thank you for your interest in organ donation and for proposing legislation to address the organ shortage.

Sincerely,

Stephen D. Haid
President

SDH/srw
cc. AOPO Executive Committee
AOPO Legislative Committee

Be an organ donor...
it's the chance of a lifetime!™

STATEMENT OF REP. CARRIE P. MEEK

before the

SUBCOMMITTEE ON SELECT REVENUE MEASURES

WAYS AND MEANS COMMITTEE

JUNE 29, 1993

TAX ISSUES AFFECTING THE HEALTH AND SAFETY OF INTERCITY RESIDENTS AND OTHER MISCELLANEOUS HEALTH RELATED TAX ISSUES

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, I WANT TO THANK YOU FOR HOLDING THIS HEARING TODAY TO EXAMINE WAYS TO IMPROVE THE HEALTH AND SAFETY OF INTERCITY RESIDENTS AS AFFECTED BY OUR NATION'S TAX POLICIES.

AS WE BEGIN TO WORK ON LEGISLATION TO REFORM OUR NATION'S HEALTH CARE SYSTEM, WE MUST DO ALL WE CAN TO IMPROVE THE HEALTH AND SAFETY OF INTERCITY RESIDENTS THROUGH PREVENTION STRATEGIES. HEALTH PREVENTION RELATES TO NUMEROUS INTERVENTIONS SUCH AS MAKING PRE-NATAL HEALTH CARE, CHILDHOOD IMMUNIZATIONS, AND ELDERLY HEALTH CARE MORE WIDELY AVAILABLE.

WHILE THESE AREAS CONTINUE TO BE IMPORTANT TO THE WELL BEING OF INTERCITY RESIDENTS, I SIT BEFORE YOU TODAY TO BRING ATTENTION TO THE DRAMATIC INCREASE OF INJURY AND DEATH TO CHILDREN BY HANDGUNS. THE HEALTH COMMUNITY IS WITNESSING A RISE IN GUN VIOLENCE ON AMERICAN CHILDREN THAT IS OUTSTRIPPING THE INCIDENCE OF CHILDHOOD DISEASES. AMERICAN CHILDREN ARE IN CRISIS DUE TO THE AVAILABILITY AND ACCESSIBILITY OF HANDGUNS.

ELEVEN CHILDREN HAVE DIED OF GUNSHOTS IN DADE COUNTY BETWEEN JANUARY AND MARCH 1993. AT LEAST ELEVEN OTHER CHILDREN WERE WOUNDED. EVERY DAY 12 CHILDREN UNDER 19 ARE KILLED BY GUNS. NEARLY 3,200 TEENAGERS FATALLY SHOOT EACH OTHER EACH YEAR. MORE THAN 135,000 STUDENTS CARRY A HANDGUN TO SCHOOL EVERY DAY. IN 1990, THE CENTERS FOR DISEASE CONTROL REPORTED THAT 29% OF THE HIGH SCHOOL STUDENTS SURVEYED HAD CARRIED A GUN TO SCHOOL AT LEAST ONCE IN THE PREVIOUS MONTH. IT IS TIME TO PUT BARRIERS IN THE WAY OF CHILDREN GETTING GUNS.

THE HEALTH AND SAFETY OF THE PUBLIC HAS BEEN SACRIFICED FOR THE CONVENIENCE AND AVAILABILITY OF GUN DEALERS AND OWNERS IN THIS COUNTRY. AS LEGISLATORS, WE MUST WORK TO ENSURE THAT THE SAFETY OF THE PUBLIC TAKES PRIORITY AS WE DEVELOP HEALTH REFORM.

I HAVE INTRODUCED LEGISLATION TO RAISE THE TAX ON HANDGUNS AND ASSAULT WEAPONS AND TO EARMARK THE FUNDS TO PAY FOR HEALTH CARE. MY BILL, H.R. 2276, THE FIREARM VICTIMS PREVENTION ACT, WHICH WAS INTRODUCED ON THE SENATE SIDE BY SENATOR PATTY MURRAY, WILL DO THREE THINGS. FIRST, IT WILL IMPOSE A 25 PERCENT TAX ON THE MANUFACTURE AND SALE OF EACH HANDGUN, ASSAULT WEAPON AND AMMUNITION FOR THESE FIREARMS. THIS WOULD RAISE THE CURRENT 10% AVERAGE TAX LEVIED ON EACH MANUFACTURER.

SECOND, IT WILL RAISE THE FEES FOR A FEDERAL LICENSE TO SELL FIREARMS FROM THE CURRENT $30 FEE TO $2,500. TODAY, ALL ONE NEEDS TO DO TO BECOME A GUN DEALER IS FILL OUT A SIMPLE, TWO-PAGE QUESTIONNAIRE AND SEND $30 TO THE U.S. TREASURY. UNLESS THE APPLICANT STATES ON THE FORM THAT HE OR SHE HAS BEEN CONVICTED OF A CRIME INVOLVING AT LEAST A ONE YEAR PRISON TERM OR IS AN ILLEGAL ALIEN, A LICENSE WILL BE ISSUED GOOD FOR THREE YEARS. THE INCREASED FEE WILL WEED OUT ALL BUT THE LEGITIMATE DEALERS, AND DOES NOT PLACE A SEVERE BURDEN ON THEM.

AND THIRD, H.R. 2276 WILL PLACE THE REVENUES FROM THESE FEES INTO A HEALTH CARE TRUST FUND TO PAY FOR HEALTH CARE.

THE PUBLIC COST OF PROVIDING MEDICAL CARE TO GUNSHOT VICTIMS IS TREMENDOUS--$4 BILLION ANNUALLY, AND MUCH OF THIS COST IS UNCOMPENSATED. PUBLIC FUNDS PAY FOR AN ESTIMATED 80 PERCENT OF THE HOSPITALIZATION COSTS OF FIREARMS INJURIES.

THE REVENUE ESTIMATED TO BE RAISED BY THE TAX AND LICENSE FEES IS $625 MILLION A YEAR. THIS REVENUE WILL FUND GRANTS TO HOSPITALS, TRAUMA CENTERS AND OTHER HEALTH CARE PROVIDERS THAT INCUR THE MAJOR COSTS OF PROVIDING MEDICAL CARE TO GUNSHOT VICTIMS.

MR. CHAIRMAN, WE MUST ACT TO PROTECT OUR NATION'S CHILDREN. I BELIEVE MY PROPOSAL GOES A LONG WAY TOWARD PUTTING OUR CHILDREN FIRST, AND I LOOK FORWARD TO WORKING WITH YOU TOWARD THAT GOAL.

# # # #

Chairman RANGEL. We will be calling Dr. Harold Freeman, who is the director of department of surgery of Harlem Hospital in New York. Dr. Freeman is not only a surgeon of renown in our Nation, but also one who has had a compassionate concern with preventing the causes of illness.

He is affiliated with Harlem Hospital through one of the greatest teaching schools that we have, Columbia University, and has recently coauthored an article that would clearly give the scientific basis of how black males born in Harlem have a lower life expectancy than people born in Bangladesh. It has received national, indeed international attention, and recently he participated in a conference on this very same subject.

I cannot think of anyone that is more knowledgeable on this subject. He has served as the president of the American Cancer Society, and I think recently was appointed by the President of the United States to what position, Dr. Freeman?

Dr. FREEMAN. Chairman of the President's Cancer Panel.

Chairman RANGEL. Chairman of the President's Cancer Panel, and still takes time out notwithstanding his other obligations to share his views with those that can make a difference. I cannot begin to tell you as a friend and as a community leader, as a doctor, as a surgeon and as an adviser to the President of the United States, how pleased we are that you would take time to share your views with us.

STATEMENT OF HAROLD P. FREEMAN, M.D., DIRECTOR, DEPARTMENT OF SURGERY, HARLEM HOSPITAL, NEW YORK, N.Y.

Dr. FREEMAN. Thank you, Congressman Rangel. It is a great honor to be here, and I thank you and the committee for inviting me. I would like to start off by saying something that we all know, and that is that there is a health care crisis in America. The country is grappling with it, and presumably health care reform which will provide access to health care for all Americans will occur.

There are 37 million uninsured American people. America and South Africa are the only industrialized countries which do not provide universal access to health care. This must be corrected, but I am here today, Congressman, not to talk simply about the point that all American people should have access to a basic level of health care, I think we can all agree to that, but more specifically I am here today to describe the special circumstances which exist in certain American communities where the death rate is extraordinarily high and the lifespan is extraordinarily short.

I have studied this issue particularly over the last 26 years that I have been working in Harlem as a surgeon. I would like to share some of my conclusions with you. As you have indicated I coauthored a paper in the New England Journal of Medicine in January 1990 which actually sent shock waves around America and throughout the world when we concluded that a black male growing up in Harlem has less of a chance of reaching age 65 than does a male growing up in Bangladesh, which is a Third World country.

Congressman, this would imply that there are Third World communities in America, and that Harlem is one such community. It certainly is not the only one. There are such communities through-

out America, and they are composed of people who are not necessarily of one particular race. I am here to talk about the circumstances in those communities that lead to an extraordinarily high death rate.

The Nation has made great progress with respect to health care results over the last 40 years. We have seen a precipitous drop in mortality among both whites and blacks in America, with whites always faring somewhat better. But in some communities, such as Harlem, and we have studies that prove this, the death rate has not declined over the last 30 years. In fact it has gone slightly up. What are the circumstances that allow such discrepencies in a society that has developed the highest technology in the world? How can a Third World community exist in the so-called First World? That is what I am going to speak about.

In the Harlem community, the causes of death, in order of number of deaths are cardiovascular disease, cancer, infectious disease—with AIDS now very predominant, and tuberculosis rising—and fourth, homicide. Many people question us related to these statistics. Many people believe—and this is somewhat related to the testimony of the last speaker, the Congressman—that homicide was the main cause of death in Harlem. Certainly, there is too much homicide in Harlem, but placing things in perspective it is important to note that only 10 percent of Harlem deaths are related to homicide. Harlem people die at a much higher rate of what I would call American diseases—cardiovascular disease and cancer.

I have studied these issue rather exhaustively, and conclude that the human circumstances in which people live, mainly defined by poverty, are the fundamental determinant of excess mortality. Poverty is associated with several negative factors: Substandard living conditions, poor educational level, risk promoting lifestyle, unemployment, poor nutrition, and lack of access to health care, particularly lack of health care that is of the preventive type. And so what makes Harlems of America distinct from the rest of America is not simply the point that people don't have early access to health care, but also they live under human conditions which I believe must be taken into account if one is going to be serious about correcting these disparities. Therefore the approach to improving health in the Harlems of America cannot be accomplished simply by providing health care.

I am disappointed, Congressman, that the debate I have heard so far on health care reform, as far as I can tell, has spoken only to the issue of providing health care to all Americans, and has not taken into account the socioeconomic conditions that lead to late diagnosis. If you gave a card to everyone in Harlem which allowed them to get into the health care system, you would not substantially solve the problem.

People are coming into the system too late for other reasons. People are coming in too late because they have other survival priorities, including food, clothing, poor living conditions, homelessness, low education and unemployment. The point that I am trying to make here, Congressman, is that we cannot correct those problems aiming only at providing access to health care. We must take into account the whole social context. I would like to go further to state that since my conclusion is that we must take a broad approach to

these issues in the inner city. It creates a special burden, I believe, for the Congress, for the Cabinet, and for the President himself. Excess mortality is deeply bound to poor housing, little education, minimal social support systems, and unemployment. I suggest, Congressman, that if we are going to be serious about approaching the health care problems in the Harlems of America, we must approach it in a broad-based way.

What I have seen so far is that bureaucracy creates barriers. The people in Housing and Urban Development try to do a job, but they probably do not relate their job to the people in Education and Labor and Health and Human Services. The severe problems in these communities will not yield to isolated approaches. You can build up the housing in Harlem without creating employment and education, and the housing simply will not work. So we are suggesting that solutions to these problems must take place across bureaucratic boundaries.

I am not very aware of what happens in the Cabinet, but I would suggest that at a Cabinet level the Secretaries of Housing and Urban Development, Education, Labor, and Health and Human Services should sit down and create a uniform plan to approach the problems in the inner city communities. Such a plan would require Congressional support. It is likely that if you approach this in this way, you would end up saving money in the long run, although it may be expensive in the beginning. We are paying for this, as you said in your opening comments, Congressman, because destructive behavior and self-destruction occurs under such circumstances. If we were to have the courage to make investments in these communities—I favor a modification of Jack Kemp's enterprise zones—we would end up saving money for the country rather than spending it.

I conclude that in seeking solutions to needs in inner city America, we take into account the broad spectrum of social and economic problems that lead to these conditions. There is a need to delineate geographical areas of excess mortality such as the Harlems of America and provide special resources. We have a good example of this already on the books. If an earthquake strikes in California, or a hurricane in Florida, and people are devastated with loss of homes and belongings, often such an area is declared an acute natural disaster zone. This triggers a response from government.

In the Harlems of America, this devastation has gone on chronically for decades, but nobody is paying much attention. I suggest that we take the same approach to what I would call the chronic disaster areas of America.

I would bring out one other point. Somehow the remedies that we provide must respect the pride, values, and the folk ways of the people that we are trying to help.

I have seen mistakes made where we decided to do something for a community, but it doesn't accept what we decide they want. Therefore I suggest if we make any plan to help people in such communities, the people themselves need to be involved in determining what we do about their destiny.

In conclusion, I would like to again say that we are into a health care crisis. The health care budget for America is approaching $1 trillion a year. The health care reform that I have heard in the de-

bate so far seems to be approaching the American public in a way that makes sense, but I have heard no debate of what will be done to address the special problems of the inner cities which have the highest death rates in the country.

I am aware of a statement by Derek Bok, the former president of Harvard University. When asked about the great expense that it would take to educate the American people, his answer was very important. He said, yes, education is expensive, but consider the price of ignorance. In keeping with this I think it is of practical significance to consider the point that an uneducated population ends up to be much more of a financial burden. A sick population and a dying population ends up as considerably more of a financial burden than a well population. And, finally, I think we have aimed our guns, as a society, to destroy the health problems of the people who can pay for the guns and ammunition. Thank you.

[Supplement to Dr. Freeman's statement follows:]

Poverty, Race, Racism, and Survival

HAROLD P. FREEMAN, MD

INTRODUCTION

Some 50 years ago Gunnar Myrdal, the Swedish economist, came to this country and studied the American socioeconomic system. He was aware of the July 4, 1776 Declaration of Independence on which the country was founded. This document declared that all men are created equal and endowed with certain inalienable rights. He knew also that at the time of this Declaration, black Americans were slaves, each one later to be counted as three-fifths of a man. In the 1940s Myrdal observed the extraordinary paradox of members of the dominant white society acting and pretending as though they were living according to the democratic principles espoused in the Declaration. This was a sham because at the time of Myrdal's analysis, Americans who were black were neither regarded under the laws nor treated as being equal. In his book *The American Dilemma*, Myrdal predicted that this national schizophrenia would lead to some form of major social upheaval (1). In the 1960s under the leadership of the Reverend Martin Luther King, Jr., this upheaval did occur. The elimination of legalized segregation followed. As a result of this social revolution, for the last quarter of a century, the laws of the country have been reasonably fair for all Americans. However, the negative socioeconomic effect of this nation's long history of racism in the form of slavery and legalized segregation is believed to be a key factor in explaining many of the disparities between races that still persist, including those related to health.

In his theory of relativity, the great theoretic physicist, Albert Einstein, described the universe as a four-dimensional time-space continuum in which observers viewing an event (such as a bolt of lightning) from different positions will see the event differently. But Einstein also showed that there is at least one constant physical phenomenon, the speed of light, which travels at 186,000 miles per second, and can always be used as a point of reference.

It is intriguing to speculate that there may be sociologic application of Einstein's theory of relativity, with the implication that individuals and groups within a given society see changing events from their own position, perspective, and bias. What you see depends on where you stand. This leads to different interpretations. Yet, hopefully, there are some fundamental truths that are constants and can be used as guides.

This "sociologic relativity" probably influences our concepts of race, our attitudes leading to racism, and the manner in which we relate to the disadvantaged such as the poor and elderly. But perhaps as Myrdal believed, the Declaration of Independence and American Constitution (documents on which the country was founded) provide for the American people moral and ethical guidelines that are constant points of reference, and serve as powerful reminders of fundamental principles of equality and justice. Americans accordingly are motivated, I believe, to question and, over time, act against social injustices.

Some Americans suffer a higher morbidity and mortality than the mainstream of American society and, in general, do not enjoy the same health status. If we could accurately identify subgroups of Americans who do not fare as well and determine the precise underlying reasons for the disparity, it might be possible to design and implement specifically targeted interventions that could lead to correction of the disparity.

For many decades the scientific community, focusing mainly on black and white differences, has documented racial disparities in disease incidence, mortality, and survival. Data have consistently shown that black Americans experience higher overall morbidity and mortality and shorter longevity than white Americans.

As an illustration of the above, I refer to a study by McCord and Freeman, which pointed out that in general, mortality rates in America have declined steadily over the last several decades both in whites and nonwhites, with the white mortality rate always lower than that for blacks. In Harlem, a community of poor blacks, however, there has been no change in mortality for the last 20 years (2) (Figure 1).

What is there about Harlem and other similar American communities that makes them different from the rest of America? This is a very important question. We find that heart disease and cancer are the number one and number two causes of death in Harlem, just as they are in the rest of America, but the mortality rates for these diseases are

Ann Epidemiol 1993;3:145–149.
From the Department of Surgery, Harlem Hospital, New York, NY.
Address reprint requests to: Harold P. Freeman, MD, Director, Department of Surgery, Harlem Hospital, 136th and Lenox Avenue, New York, NY 10037.
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1047-2797/93/$06.00

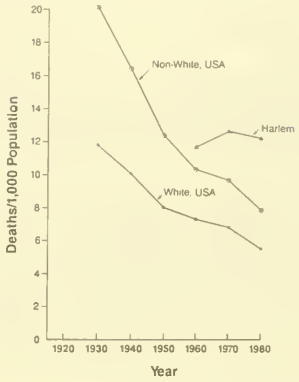
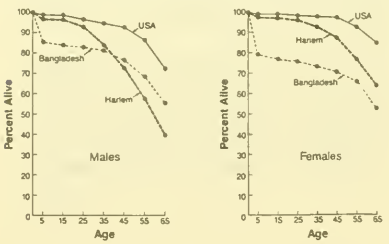


FIGURE 1. Age-adjusted death rates in Harlem (1960 to 1980) and the United States (1930 to 1980). Reprinted, by permission of The New England Journal of Medicine (174, 1990).

strikingly higher in Harlem. However, the third and fourth causes of death in Harlem, unlike the rest of America, are cirrhosis and homicide. Most dramatically, we found that if you are a male in Bangladesh, you have a better chance of living to age 65 than you do if you are a male growing up in Harlem (Figure 2). One way, therefore, to look at Harlem is to see it as a Third-World community within the first world. So you really do not have to travel 8000 miles to visit the Third World. If you are in New York City, just take the A train to Harlem, as Duke Ellington would have said.

Since the early 1970s, data from the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute have shown that black Americans experience higher cancer incidence rates and lower survival rates than white Americans do. Currently, black Americans with cancer have a 38% 5-year overall survival rate and whites, a 50% rate.

FIGURE 2. Survival to the age of 65 in Harlem, Bangladesh, and among US whites in 1980. Reprinted, by permission of The New England Journal of Medicine (174, 1990).



A major report issued in 1986 by the American Cancer Society concluded that controlling for socioeconomic status greatly reduces, and sometimes nearly eliminates, the apparent mortality and incidence disparities in cancer between ethnic groups. The report further concluded that ethnic differences are largely secondary to socioeconomic factors in contributing to these disparities, and that the overall cancer survival rate is 10 to 15% lower in the economically disadvantaged (3).

There is no question that a significant morbidity/mortality gap exists between black and white Americans. Of substantive importance, though, is whether or not race in and of itself is the fundamental determinant of these dispartities. It is critical also to understand the significance of racism and economic status as determinants of the morbidity/mortality gap.

To reach some degree of understanding, it is necessary to distinguish between the meanings of race, racism, culture, and class (economic status). If we fail to disentangle the meanings of these distinct social elements, if we merge them into some sort of intellectual melting pot, we will tend to confound our ability to provide meaningful solutions.

In keeping with this discussion, let us first attempt to separate the meaning of poverty from the meaning of race.

POVERTY

Who are the poor in America? Fourteen percent of American people, 35.7 million, live below the poverty line, which is currently $13,924 for a family of four (4). When one looks at poverty according to race, we find that nearly one-third of the poor in America are black, and two-thirds are white. But blacks make up only 12% of the American population, so that the effects of poverty are disproportionately reflected in the black population. Looking at it a different way, one-third of black Americans are poor, whereas only 11% of white Americans are poor. So, it is conceivable that one might look at black Americans and think of poor Americans, and that one might look at white Americans and think of middle-class Americans. In fact, both blacks and whites living in poverty face rather similar adverse circumstances in this country and in the world in general. The Bureau of the Census reports that at the same income, white Americans are ten times wealthier than black Americans. Wealth, which indicates net worth, is a more robust indicator of human circumstances than income, which is a snapshot showing 1 year's earnings. This fact could help in explaining why in some studies, blacks at the same income level have somewhat more severe health problems than whites.

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Poverty is associated with low educational level, substandard living conditions, an inadequate social-support network, unemployment, poor nutrition, risk-promoting lifestyle, and diminished access to health care. Diminished access is often manifested by low quality and inadequate continuity of health care, as well as insufficient access to methods of disease detection, diagnosis, and treatment and to rehabilitation. Moreover, poor people tend to concentrate on day-to-day survival, often develop a sense of hopelessness and powerlessness, and may become socially isolated.

Accordingly, poverty is a proxy, or a surrogate, for a complex series of negative social events. It is likely that poverty is a proxy for different social realities in other countries such as Sweden, which provides a higher level of social support to its citizens compared to the United States. This suggests that societies can modify the effects of poverty through system changes.

In addition, further compromising the health of Americans is the lack of universal access to health care. An estimated 35.4 million Americans do not have health insurance. Less than half of the poor are poor enough to receive Medicaid. Consequently, there are about 17 million uninsured poor people who are too rich for Medicaid, but still too poor for Blue Cross. Nearly 20 million uninsured Americans live above the poverty level. America's poor and uninsured overlap in such a way that more than 55 million Americans (one out of four) are either poor, uninsured, or both (5).

RACE

Race may be seen in its genetic, cultural, and historical meanings, any or all of which may be significant.

To date, there is no known genetic basis to explain the major differences in disease incidence and outcome between races. Moreover, the term race takes on different meanings in different geopolitical settings. As indictaed by Cooper (6), race is fundamentally a social concept as opposed to an indicator of significant biologic differences. In general, people do not innately develop or die from diseases because of their race. Furthermore, there is no evidence that race bestows biologic advantages or disadvantages. We conclude, therefore, that race as an indicator of genetic variation does not seem to provide the critical explanation for why blacks, whites, Asians, and others differ with respect to diseases.

Viewed from another perspective, race may be seen as a gross variable for culture. If, for example, a population designated by race has common ancestors, similar social and physical environment, and a shared communication system, its members will tend to have a similar tradition, value system, belief system, and world view. These shared elements lead to common life-styles, attitudes, and behaviors. Such cultural factors deeply influence health status, and any successful intervention must necessarily take these powerful cultural realities into account.

Having distinguished poverty from race and having separated the cultural meaning of race from its genetic meaning, let us directly address a major question: What is the effect of racism on health status?

RACISM

The history of a given racial group can be a powerful determinant of the current socioeconomic status of that group. As a dramatic example, consider the fact that historically, black Americans have been legally free in this country for only 25 years, having prior to that experienced 250 years of slavery and 100 years of legalized segregation.

The history of Native Americans is even more shocking. These are people who discovered Columbus on their land some 500 years ago, ended up primarily on reservations, and suffer the poorest health and the highest mortality in America.

To the extent that racism is a cause of poverty and ignorance (as it is for blacks and Native Americans), racism becomes an indirect but critical factor in causing disease and death.

INTERRELATIONSHIPS BETWEEN RACE, POVERTY, AND SURVIVAL

I would like to offer this model of how poverty and race, as culture, interact to influence survival. While neither race nor poverty is an absolute indicator of disease incidence and survival rates, each is a surrogate of predictable conditions and circumstances. Setting aside historical considerations, the significance of race with respect to disease is generally limited to race as an indicator of a specific culture and lifestyle. I conclude, however, that economic status, irrespective of race, prevails as a more powerful surrogate of human conditions and circumstances.

I theorize that poverty acts through the prism of culture—a factor that can either diminish or accentuate poverty's negative effects. For example, poor people belonging to a culture whose members do not smoke, do not drink alcoholic beverages, and have a low-fat, high-fiber diet (such as the Seventh Day Adventists) will have diminished risk factors compared with those in a culture whose members smoke and drink heavily and consume a high-fat, low-fiber diet (such as the cultures in Harlem and Appalachia). On the other hand, irrespective of culture, poor people have diminished access to health care (7) (Figure 3).

This model may also help us to understand the role racism plays in the development of disease. Historically, racism

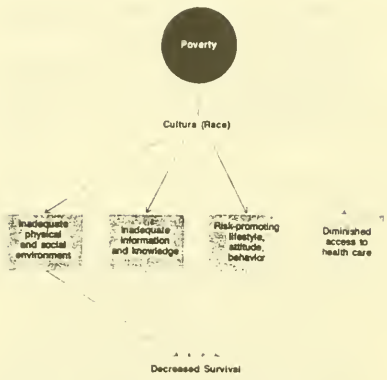

FIGURE 3. Interrelationships between poverty, race, and survival. Poverty acts through the prism of culture (race). From Freeman (5).

has been a powerful force in determining who lives in poverty. To the extent that racism still exists, it could have an effect at almost any stage of the model, especially as a contributor to substandard living conditions. However, I believe that if people can escape poverty, particularly if they achieve a moderate range of income, they will tend to escape the effects of racism as a determinant of access to health care. This is to say that despite the continuing destructive social effects of racism, the level of health care that one receives in present-day America is related primarily to economic status rather than to race.

CONCLUSIONS

Racism and poverty are interrelated destructive elements within the American society that have created the morbidity/mortality gap between the races. As America has undergone the transitions from slavery to emancipation with legalized segregation and finally to legal equality for all citizens, the relative *proximate* role of racism in causing health disparities has gradually diminished. Disproportionate poverty has become the dominant cause of these disparities. This implies that in contemporary America, disease prevention and access to diagnosis and treatment (factors that determine health status) are primarily related to level of education and economic status. With few exceptions, individuals of any race who can pay for services are not denied treatment.

With these thoughts in mind, we must define strategies to correct the effects of poverty and resultant poor health. Such strategies should not be confused with equally essential strategies that are intended to eliminate racism.

I conclude that the disproportionate degree of poverty in black Americans is the key underlying cause of the morbidity/mortality gap between black and white Americans. The relatively poor health status of black Americans is an indication of the health consequences that befall a racial group that represents one-third of the poor, one-fourth of the unemployed, but only one-tenth of the population. Historical racism has been a significant determinant of the low socioeconomic status of black Americans. There is no genetic basis for major racial differences in disease outcome. Race, on the other hand, is a powerful proxy for culture, tradition, belief system, value system, and life-style. Thus race (as culture) becomes a prism through which the effects of poverty are reflected.

The concentration of resources on high-risk groups is an accepted medical principle in attempting to achieve substantially improved survival rates, whether one is dealing with infectious disease, neoplastic disease, cardiovascular disease, or other forms of illness. Convincing evidence has accumulated to show that low socioeconomic status, regardless of race, is a major determinant of higher morbidity and mortality. Poor Americans, therefore, constitute a high-risk group for disease and death. Accordingly, substantial resources should be directed toward disease prevention, diagnosis, and treatment in the poor.

RECOMMENDATIONS

Universal access to health care including prevention and treatment should be provided to all Americans, irrespective of their ability to pay. All concerned Americans should become advocates for such change.

Geographically and culturally defined areas of extreme excess mortality in America (Third-World communities) should be delineated and designated as "chronic disaster areas." Accordingly, special federal, state, and local resources should be provided to such designated areas, as is commonly done in cases of severe natural disaster areas.

In such communities, simply providing access to health care will not substantially improve survival. Fundamental solutions require a simultaneous approach (across bureaucratic boundaries) to improving certain measurable conditions that are rooted in poverty. These conditions include substandard housing, low educational level, poor social-support network, and unemployment as well as insufficient access to preventive health services.

At the federal level, key cabinet members including the secretaries of Health and Human Services, Education, Housing and Urban Development, and Labor should prepare a comprehensive plan encompassing a unified ap-

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proach to improving living conditions, employment, education, and health care in these disaster areas. Implementing such a plan will require cooperation and support from the Congress and State and local government officials as well as the private sector.

Critical to any successful intervention is the provision of culturally targeted education, especially to the young, to promote healthy life-styles. Moreover, since an understanding of cultural differences is fundamental in promoting life-style changes, an anthropologic approach to public education is essential.

Any intervention intended to diminish mortality and improve survival must take into account the pride, values, and folkways of the people we are trying to help.

Each individual, regardless of economic status, must share in the responsibility for promoting his or her own health and well-being.

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Chairman RANGEL. Thank you, Dr. Freeman. My staff is not here, but I am going to ask at some point that Jon Sheiner or the staff of the subcommittee share with you some of the work that we have done with the last administration. I hope that back home we can get together and perhaps I could get the benefit of your expertise coupled with some legislative initiatives. Because what I had been able to do with Dick Darman, who was the Director of Office of Management and Budget, recognizing that we could not get a majority of the votes for programs designed directly to relieve poverty. We don't have the money for preventive care. We don't have the money for job training, and yet I was able to show that we do have the money for intensive care.

We do have the money for the homeless after they cause a problem. We do have the money to keep people in jail at the cost of $60,000 a year. We do have the money to call out the National Guards when there are explosions, and we do have the money to attempt to restore businesses that have been destroyed as a result of these communities exploding. So I asked Darman to share with me what is really the cost of doing nothing. What is the cost of neglect, and how much in dollars and cents are we losing as a Nation. I asked whether they took those figures and added on to that the potential to America in terms of the revenues that are lost in taxes and also the lost productivity because you cannot possibly think of how much money you are losing when you pay for someone being kept in prison. There is just nothing less productive. They came up with the astounding figure, which they claimed was conservative, of $300 billion a year. Secretary of the Treasury Brady said that was a low estimate. That that was the best they could come up with. So we did after that pretty close to what you were talking about.

We then said that if there is going to be a war, we would target the greatest threat to our troops. When I was in combat we would do it by the number of soldiers, the number of mortars, the number of artillery pieces, the backup. We would know either what had to be destroyed or what had to be avoided. But we would normally concentrate our power on those areas where the enemy would be. If you concentrated in those areas in our Nation by putting up pins for mortality rate, the drug rate, the crime rate, the teenage pregnancy rate, the homelessness rate, the joblessness rate, you would see clusters forming on the map. Well, clearly you would know that is where you are hemorrhaging in human life and that is where you are hemorrhaging in expenses.

Now, the Kemp enterprise zone bill always provided for tax incentives to businesses. The reason it was never considered by the Congress is that many of us thought that you just don't give tax incentives, that is tax preferences, to a company coming in to a war zone where there is inadequate housing and health care and an inadequate work force without creating a climate very much like you would do in a developing, country, if you will. If you wanted to build a business, you have to find out if the work force trained, if there is a crime problem, a health problem, a housing problem. You have to create an atmosphere and then give the incentive. So after Los Angeles we were able to get legislation. It was incorporated in a larger bill. It was vetoed by President Bush. We passed it again

in the House of Representatives this year. It was dropped by the Senate, but I wish some kind of way that we could take all of the experts in all of the different areas of concern and bring them together as you have provided the leadership in the medical area.

You mentioned what good is decent housing if people don't know how to live in it? What is the sense in talking about giving jobs, and I say the same thing with our job program. You say access to health care doesn't count if people are too sick really that it is too late for them. They need something right now to allow them to get access to decent health care. I have said something which is the same thing, but when you have job programs and you bring them to communities where the people are unemployable, then you have got to go beyond just creating the jobs. You have got to make certain that the people are able to work through training. So I want to work with you and see whether if I can show you the attention and the support that we have for this concept, and you can share with me from your national perspective.

I think it is time that we stop talking about the poverty in the urban and rural areas. That is not getting us anywhere. We can't even talk about doing the right thing. We can talk about doing it for Russia because we can't disappoint them. They are relying on us. We need trading partners in Mexico, so we have to invest there, too. But somehow the poor, whether they are in Harlen, Ky., or Harlem, N.Y., we wish we could do more, but we just don't have the money now. But if we start talking about how much we are spending just by not doing anything, I think we can get a lot more attention. I just look forward to trying to bring a little more professionalism and partnership into our relationship to see how we can build a political force that will demand attention.

I can't thank you enough for your commitment. That is even more important than your eloquence.

Dr. FREEMAN. Thank you.

Chairman RANGEL. Mr. Hancock.

Mr. HANCOCK. No questions.

Chairman RANGEL. Mr. Hoagland.

Mr. HOAGLAND. No questions.

Chairman RANGEL. Mr. Kopetski.

Chairman RANGEL. Well, I guess you have said it all, doctor. Let's see whether we can get together.

Dr. FREEMAN. There is one final statement, Congressman. I mentioned we are in a crisis, but the Chinese word for crisis also means opportunity, so maybe we should look at it that way; take the crisis and make it into an opportunity to solve these desperate problems in the inner city. Thank you very much.

Chairman RANGEL. We have to find out how we can mobilize our forces. The mayors of our country, they face the crisis. The moneys they get, they have to pay for this hemorrhage. They are putting more in police than they are in schools. They know it is wrong, but they have to do it for political reasons. Let's see whether or not money that doctors and hospitals are not getting, but who really are having to put their fingers in the holes in the dike; whether we can bring them together. So that teachers can teach instead of being disciplinarians; that doctors can prevent people from being sick rather than being compensated for surgery that doesn't work.

Let's see whether we can bring the forces together in a political way that we can get the President's attention.

Dr. FREEMAN. Thank you for the opportunity to testify, Congressman.

Chairman RANGEL. Thank you, doctor.

Next panel, Diane Rowland, executive director of the Kaiser Commission on the Future of Medicaid; Arthur Cooper, division of pediatric surgery, Harlem Hospital, American Academy of Pediatrics; Gerald Schenken, Dr. Schenken, member of the board of trustees of the American Medical Association from Omaha, Nebr. They are a very qualified panel of experts that we deeply appreciate the fact that you have taken time to share your views with us, and I yield to Mr. Hoagland for the purpose of recognizing the doctor from Nebraska.

Mr. Hoagland.

Mr. HOAGLAND. Well, Mr. Chairman, I would simply like to welcome Dr. Schenken to the subcommittee. Dr. Schenken is a veteran witness before the Ways and Means Committee, having previously testified on behalf of the AMA several times. He is an able advocate and even though Dr. Schenken and I are members of opposite political parties, we have maintained our personal friendship. I appreciate that. So welcome to the committee, Dr. Schenken.

Dr. SCHENKEN. Thank you. Thank you, Mr. Chairman.

Chairman RANGEL. Thank you. Let me thank this entire panel. We need your expertise. Dr. Schenken.

I am sorry, Diane Rowland is the first on the panel.

STATEMENT OF DIANE ROWLAND, EXECUTIVE DIRECTOR, KAISER COMMISSION ON THE FUTURE OF MEDICAID, BALTIMORE, MD.

Ms. ROWLAND. Thank you, Mr. Chairman, for this opportunity to testify today on the pressing health problems of urban America. I am Dr. Diane Rowland, associate professor of health policy and management at the School of Hygiene and Public Health at Johns Hopkins University and serve as the executive director of the Kaiser Commission on the future of Medicaid.

What I would like to talk about today are the problems of low-income Americans and the particular concerns that arise in meeting the health care needs of the poor in urban America. The poor have lower health status and greater health needs than other Americans. Despite their greater health needs they use fewer physician services, have less access to care, and are more likely to be uninsured than other Americans. This results in severe and growing health problems in urban America and places our safety net providers under tremendous stress, and underscores the need for both insurance reform and infrastructure reform in our inner cities.

Poverty and poor health are unfortunately inextricably linked in America and too often concentrated in inner cities. This link is demonstrated by the lower self-reported health status and higher rates of low birth weight, childhood conditions, mental illness, chronic conditions and infectious diseases of the poor in contrast to the nonpoor population.

One in 3 poor adults compared to less than 1 in 10 affluent adults is in poor health. The poor are more likely to suffer both

acute illnesses as well as chronic conditions that require ongoing medical treatment and management.

These conditions, including arthritis, heart disease, and diabetes, often require expensive medications and can result in severe disability and even death if appropriate and timely care is not delivered. I have attached some handouts to my written statement that provide graphic illustrations of the illness levels among the poor population, showing rates of heart disease and diabetes as well as mental illness for the poor at twice the levels of those of the nonpoor.

AIDS, and now an increasing rise in tuberculosis, are also disproportionately found in low-income areas, but most pressing is that today poor children in inner cities and underserved areas are particularly at risk for health problems. Inadequate prenatal care and environmental factors combine to leave too many children impaired throughout life by conditions that are preventable during youth.

In New York City a recent study found twice as many low birth weight births occur in the poorest neighborhoods as in the wealthiest neighborhoods. Immunization rates among poor children are far lower than those for higher income children. Lead paint in the home is a serious additional risk to the well-being of poor children that can result in mental deterioration if undetected and untreated. The risk is greatest for the poor.

Analysis of 1984 data found 41 percent of children living in poor households had lead poisoning compared to 17 percent of children in families with incomes over $15,000.

Mr. Chairman, inadequate prenatal care leading to low birth weight babies, low immunization levels, and contamination from lead paint are all prevalent conditions in the inner city that can be eliminated with adequate resources and strengthened public health activities. These must be a priority in health care reform, but these conditions also all point out that today the poor do not have adequate access to health care services. Despite their greater health needs the poor are less likely to see a physician and use fewer physician visits during a year than the nonpoor.

A third of the poor had no visits in the prior year compared to 23 percent of the nonpoor. The availability of insurance coverage, however, has a significant impact on the likelihood of receipt of care and cannot be understated. Forty-four percent of the uninsured poor went without a physician visit in the previous year compared to only 19 percent of the poor with Medicaid coverage.

Despite perceptions that the poor overuse the health care system, utilization rates for physician services for the poor are lower than for the nonpoor. Average annual numbers of physician visits in 1987 for the poor were 3.8 visits per year compared to 4.6 visits for the poor. Some of the progress we have seen in previous years in narrowing the gap between the poor and the near poor also appears to now be opening in recent years. When the poor do seek medical care, their site of care is often different from that of the nonpoor. They are less likely to be cared for in a private physician's offices and more likely to rely on care from clinics, hospitals, and emergency rooms. Clinics and hospital outpatient departments ac-

count for nearly one-third of medical contacts by the poor, compared to 20 percent of visits by the nonpoor.

The poor are more than twice as likely as the nonpoor to receive care in an emergency room, but it is worth noting that even for the poor, emergency room use represents a very small proportion of total care; 6 percent of all visits by the poor are to emergency rooms compared to 3 percent of visits by the nonpoor.

The care delivery patterns of the poor reflect the environment in which they live. Lack of insurance coverage limits choice of provider and focuses care on hospitals and clinics where insurance cards are not required for entry. Lack of an adequate supply of physicians and other health providers in many urban areas also constrains choice and concentrates care in the facilities that are available.

Today a third of 32 million nonelderly people in households with incomes below the Federal poverty level are without insurance, compared to 9 percent of the nonpoor. Medicaid, our joint Federal-State program for financing health care for the low-income population covers less than half of the poverty population. Congressionally mandated expansions have broadened Medicaid coverage to two-thirds of all poor children and required coverage of pregnant women with income below 133 percent of poverty, but the poor without children remain categorically ineligible for Medicaid unless they qualify as disabled. State variations in income and resource levels across the States result in residential differentials in the percent of poor covered by Medicaid.

Medicaid coverage is essential to the poor because few have access to private insurance, even if they are employed. Over half of the 32 million poor live in households with an adult worker, but only 11 percent of the poor receive employer-based coverage. Even the poor who work all year at a full-time job are not guaranteed employer coverage. Only a quarter of full-year, full-time workers and their families with incomes below poverty receive employer coverage, compared to 84 percent of the nonpoor working population. This disparity reflects the fact that poor individuals are more likely to work in low wage and small firms which do not today supply health insurance.

The combination of strict eligibility requirements for Medicaid, along with inconsistent and inadequate coverage by employers leaves severe gaps in health insurance coverage for the poverty population. Without an insurance card, the uninsured poor turn to inner city hospitals and clinics for the care they need. Often they wait until conditions have worsened to seek care, resulting in more serious illness and expensive treatment when care is ultimately rendered. The safety net providers to whom they turn are faced with growing demand, but highly constrained resources. The result is a health system in stress and impaired access to care for millions of Americans.

Chairman RANGEL. What page are you on in your testimony?

Ms. ROWLAND. Pardon me?

Chairman RANGEL. What page are you on in your testimony?

Ms. ROWLAND. I am on page 3.

Chairman RANGEL. Because we normally reserve to 5 minutes for the testimony, and I think you have 9 pages.

Ms. ROWLAND. I was just going to very briefly go through two more issues with regard to some statistics from New York City and then conclude.

Chairman RANGEL. Because we have four additional panels, it will be necessary to try to stick within the 5-minute rule.

Ms. ROWLAND. OK. I mostly wanted to point out that in the statement we have analyzed health care utilization differences for hospitalizations between Harlem and Bronx and between Westchester County and Nassau County. I think the statistics there clearly show the impact of trauma, of AIDS, and of all of the kinds of conditions we have just talked about on the facilities in inner cities and their ability to render care and the amount of care that is delivered. I would just conclude my statement by saying that these statistics point out that in order to face the problems of inner cities, we need to provide not only an insurance card but also to work extensively to build the infrastructure and make resources available in the inner cities to provide the kind of public health activities as well as medical care activities we need. I would urge that in health care reform we work not only toward universal insurance coverage for all Americans, but also strongly support efforts to build better delivery systems and better public health capacity in our inner city areas. Thank you.

[The prepared statement and attachments follow:]

Diane Rowland, Sc.D.
Testimony before the Subcommittee on Select Revenue Measures
Committee on Ways and Means
U.S. House of Representatives
June 29,1993

Thank You, Mr. Chairman, for this opportunity to testify on the pressing health problems of urban America. I am Dr. Diane Rowland, Associate Professor of Health Policy and Management at the Johns Hopkins School of Hygiene and Public Health and Executive Director of the Kaiser Commission on the Future of Medicaid.

The Kaiser Commission was established in 1991 by the Henry J. Kaiser Family Foundation to function as a Medicaid policy institute and to serve as a forum for analyzing, debating, and proposing future directions for health care for poor and vulnerable populations. The fifteen member national commission is chaired by the Honorable James Tallon, Majority Leader of the New York Assembly.

I am pleased to be here today to share the work of the Commission and discuss the health problems of low-income Americans and the particular concerns that arise in meeting the health care needs of the poor in urban America. My statement will review the health status of our nation's poor, the role Medicaid plays in helping to finance their health care, and the financial and non-financial barriers that often compromise and complicate access to care in our inner-cities, as well as in many rural areas.

Health Status

Poverty and poor health care are, unfortunately, inextricably linked in America and too often concentrated in our inner-cities. This link is demonstrated by the lower self-reported health status and higher rates of low birthweight, childhood conditions, mental illness, chronic conditions and infectious diseases of the poor in contrast to the non-poor population.

Poor health is more commonly experienced by the poor than by those with higher incomes. One in three poor adults compared to less than one in ten affluent adults reports their health as fair or poor.

The poor are more likely to suffer both acute illnesses as well as chronic conditions that require on-going medical treatment and management. Chronic conditions including hypertension (high blood pressure), arthritis, heart disease, and diabetes often require expensive medications and can result in severe disability and even death without appropriate and timely care.

- *Chronic Illness*: Nearly a quarter (24 percent) of the poor have high blood pressure compared to 20 percent or less of the non-poor. Rates of heart disease and diabetes for the poor are twice the levels for the non-poor.

- *Mental Illness*: Thirty-nine per 1000 poor adults, compared to 16 per 1000 non-poor adults report a serious mental illness (Barker et al, 1992).

- *Infectious Diseases*: AIDS, and now an increasing rise in tuberculosis, are disproportionately found in low-income areas. A recent study in Philadelphia found rates of 47 cases per 100,000 for people with incomes under $6,622 and 20.6 cases per 100,000 for people with incomes over $10,151 (Fife and Mode, 1992).

Today, poor children in inner-cities and underserved areas are particularly at risk for health problems. Inadequate prenatal care and environmental factors combine to leave too many children impaired throughout life by conditions that are preventable during youth. Inadequate prenatal care leading to low birthweight babies, low immunization levels and contamination from lead paint are all prevalent conditions in the inner-city that could be eliminated with adequate resources and strengthened public health activities.

- *Low Birthweight*: Poor women are at high risk of having babies of low birthweight, a leading cause of infant mortality and disability. The rate for low birthweight babies among the poor is 10 percent for whites and 12 percent for blacks in contrast to four percent and eight percent respectively for the non-poor (Starfield, et al 1991). In New York City, a recent study found twice as many low birthweight births occur in the poorest neighborhoods as in the wealthiest neighborhoods (Greater New York March of Dimes, 1993).

- *Immunizations*: Once children are born into poverty stricken households, they are less likely to receive health services which could prevent diseases. Immunizations rates are lowest among the poor. Only 68 percent of poor school-age children are immunized against measles compared to 83 percent of higher income children (NMES, 1987).

- *Lead Poisoning*: Lead paint in the home is a serious additional risk to the wellbeing of poor children resulting in mental deterioration if undetected and untreated. Poor children are more at risk for lead poisoning than are their higher income counterparts. Analysis of 1984 data concluded that 41 percent of children living in households with an income of less than $6000 had lead-poisoning compared to 17 percent of children in families with income over $15,000 (Agency for Toxic Substances and Disease Registry, 1988).

USE OF MEDICAL CARE

Given the lower health status of the poverty population and the importance of medical care for the treatment of their illnesses, one would expect higher medical care utilization rates for lower income than higher income individuals. In fact, the opposite is true. Despite their greater health needs, the poor are less likely to see a physician and use fewer physician visits during a year than the non-poor.

Comparisons of health status and utilization between the non-elderly poor and the non-poor (defined as those with incomes above twice the federal poverty level) in 1987 reveals striking differentials in access to care for the poor. A third of the poor (32 percent) had no physician visits in the prior year compared to 23 percent of the non-poor. The availability of insurance coverage, however, has a significant impact on the likelihood of receipt of care by the poor. Forty-four percent of the uninsured poor had no physician visits during the year compared to only 19 percent of the poor with Medicaid coverage.

Despite perceptions that the poor overuse the health care system, utilization rates for physician services for the poor are lower than for the non-poor. The average annual number of physician visits in 1987 for the poor was 3.8 physician visits compared to 4.6 visits for the non-poor. When utilization among those in fair or poor health is examined to adjust for health status, the poor continue to lag behind with 6.4 visits per year compared to 8 visits for the non-poor.

When the poor do seek medical care, their site of care is often different from that of the non-poor. The poor are less likely than their non-poor counterparts to report that the site of care for the majority of their visits is in a physician's office. Only 57 percent of the poor compared to 75 percent of the non-poor receive the majority of their care in physicians' offices.

Many of the poor receive their care from clinics, hospitals and emergency rooms. Clinics and hospital out-patient clinics account for nearly a third (31 percent) of medical contacts by the poor and 20 percent of visits by the non-poor. The poor are more than twice as likely as the non-poor to receive care in emergency rooms, but even for the poor, emergency room use represents a very small portion of total care. Six percent of all visits by the poor are to emergency rooms compared to three percent of visits by the

non-poor.

Having a regular source of medical care is viewed as a measure of access to care because a stable medical provider relationship helps to foster use of preventive care and early intervention for treatment of disease. In addition to having fewer visits per year, the non-elderly poor are less likely than the non-poor to have a regular source of care. A quarter of the poor compared to 19 percent of the non-poor do not have a regular source of care.

The care delivery patterns of the poor reflect the environment in which they live. Lack of insurance coverage limits provider choice and focuses care on hospitals and clinics where insurance cards are not required for entry. Lack of an adequate supply of physicians and other health providers in many urban areas also constrains choice and concentrates care in the facilities that are available.

Health Care Coverage

Given their lower health status and greater expected need for medical care, health insurance to provide protection for medical expenses and to broaden access to care is critical for low-income families. Yet today, a third of the 32 million non-elderly people in households with incomes below the federal poverty level are without insurance compared to nine percent of the non-poor -- those with incomes 200 percent of poverty or greater. Access to care for the uninsured poor depends on the availability of a community health center, a hospital emergency room, a public health department clinic, or charity care from a public or non-profit hospital.

Medicaid, our joint federal-state program for financing health care for the low-income population, covers less than half (45 percent) of the poverty population. Congressionally mandated expansions have broadened Medicaid coverage to two-thirds of all poor children and required coverage for pregnant women with incomes below 133 percent of poverty. However, the poor without children remain categorically ineligible for Medicaid unless they qualify as disabled under the Supplemental Security Income (SSI) cash assistance program. Moreover, state variations in income and resource levels across the states result in residential differentials in the percent of the poor covered by Medicaid.

Medicaid coverage is essential to the poor because few have access to private insurance -- even if they are employed. Private health insurance does not cover most low-wage workers. Over half (55 percent) of the 32 million poor live in households with an adult worker, but only 11 percent of the poor receive employer-based insurance. Even the poor who work all year at a full-time job are not guaranteed employer-based coverage. Only a quarter of full year, full-time workers and their families with incomes below poverty receive employer coverage compared to 84 percent of the working population with incomes above 200 percent of poverty. This disparity reflects the fact that poor individuals are more likely than the non-poor to work in low wage and small firms which do not supply health insurance.

The combination of strict eligibility requirements for Medicaid along with inconsistent and inadequate coverage by employers leaves severe gaps in health care coverage for the poverty population. Without an insurance card, the uninsured poor turn to inner-city hospitals and clinics for the care they need. Often they wait until conditions have worsened to seek care, resulting in more serious illness and expensive treatment when care is ultimately rendered. The safety net providers to whom they turn are faced with growing demand, but highly constrained resources. The result is a health system in stress and impaired access to care for millions of Americans.

INNER-CITY HEALTH PROBLEMS

The poor health of low-income individuals translates to high rates of certain

conditions in urban areas with high concentrations of poverty. What does this mean for our inner-cities and the poor who live within them? What conditions are the poor treated for and how do these conditions differ from those of the more affluent population? Do the poor receive the same or different treatment for the same diagnoses as the non-poor? What providers care for the poor and how do patterns of care differ for the poor from the non-poor?

To be able to respond to these questions and improve our understanding of care delivery patterns by different income groups, the Kaiser Commission on the Future of Medicaid has undertaken an analysis of data from the Codman Research Group. Patient-origin analysis based on hospital discharge records from 18 states that is linked to the income of the zip-code of residence allows us to compare hospital use between low and high income communities.

Preliminary findings from this analysis demonstrate that poor inner-city communities experience higher rates of hospitalizations and longer length of stays for certain conditions than do more affluent communities and that the factors leading to these admissions differ significantly. Residents of low income areas are more likely to be admitted for conditions amenable to early treatment on an ambulatory basis and less likely to be admitted for elective procedures than people from higher income communities.

Looking specifically at New York, low-income inner-city areas (Harlem and Bronx) had higher rates of hospital admissions for conditions treatable by ambulatory care (ambulatory care sensitive conditions), infectious conditions, mental conditions and trauma than did residents of higher income counties outside of New York City (Westchester County, Nassau County).

- *Ambulatory Care Sensitive Conditions*: The rates of hospital admissions for ambulatory care sensitive conditions provide a particularly striking contrast between income areas in New York. Ambulatory care sensitive conditions -- conditions which include asthma, diabetes and hypertension -- can often be treated in an outpatient setting to avert a hospitalization. The overall ambulatory care sensitive admission rate in Harlem was three times greater than that in Westchester and Nassau Counties (54 admissions per 1000 residents compared to 19 per 1000 and 17 per 1000 respectively).

- *AIDS*: Similarly, the AIDS epidemic has clearly hit the inner-city with much greater force than other areas. The 18 state total rate for HIV related hospital admissions was 0.56 admissions per 1000, while that for Harlem was 8.73 and that for the Bronx was 3.96 per 1000 residents. AIDS is particularly devastating for young adults in cities and is now the leading cause of death for males aged 25-44 in 64 cities. It is the leading cause of death for women in the same age group in nine cities (Selik, Chu, Buehler, 1993).

- *Tuberculosis*: Paralleling income trends, inner-city populations are at much higher risk for infectious diseases such as tuberculosis. The Harlem admission rate for tuberculosis was over 20 times greater than the average for all 18 states in the study (2.37 admissions per 1000 residents in Harlem compared to 0.1 per 1000 in the 18 state sample). Westchester and Nassau County rates resemble the total 18 state rate.

- *Trauma:* The impact of violence in inner-city neighborhoods can be inferred by analyzing admissions for trauma. Comparison of trauma admissions (which includes admissions due to accidents and other injuries) for males aged 18-24 shows a rate in Harlem over two times that of either Westchester or Nassau county (24 admissions per 1000 residents in Harlem, compared to 12 per 1000 in Westchester and 10 per 1000 in Nassau).

Violence, the cause of many emergency room visits, injuries, and deaths, has become an overwhelming concern in the inner-city, as evidenced by the rise in mortality rates attributable to firearm homicides. The disparity between black and white rates is astounding, with the rate for black males of 34 deaths per 100,000 -- a rate nearly 5 times greater than that for white males (CDC, 1992).

- *Drugs*: The disproportionate use of drugs in the inner-city is evidenced by the rate of drug related admissions in these areas, as compared to rates elsewhere. In 1990, the drug related hospital admission rate in Harlem was approximately 12 times greater than both the 18 state and Nassau county rates (23.11 admissions per 1000 residents in Harlem compared to 2.33 per 1000 for the 18 state average and 2.03 per 1000 in Nassau county).

These comparisons of health care utilization in the inner-city areas of New York in contrast to outlying counties underscores the complexity and seriousness of the health problems in the inner-cities and the stresses that the health providers in these areas face. There is no single explanation for the high rates of ambulatory care sensitive conditions, infectious conditions or violence in poor and inner-city populations. Rather, a variety of variables related to the health needs and delivery system, but also related to social and financial factors, must be examined in order to identify the causes of this population's poor health status, and to be able to make recommendations for meeting its health needs.

CORRECTING INNER-CITY HEALTH PROBLEMS

Today, our inner-city areas face serious health problems. Access to primary and preventive services for inner-city residents is often compromised by inadequate resources and lack of insurance to finance care. Provision of needed care is further complicated by the growing demands on an already over-extended health system caused by AIDS, tuberculosis, substance abuse, violence, and the other devastating conditions that continue to plague the inner-city.

It is time to break the cycle of poor health, poverty, and inadequate resources in our inner-cities. Clearly, the provision of universal insurance is essential so that no American delays care or is denied care because they cannot pay. Affordable insurance coverage for all must be a national priority and it is time to make the potential of coverage a reality for all Americans. But, when we look at our nation's cities and the complex social and health problems that confront them, we must recognize that an insurance card alone will not solve all of these problems.

Universal coverage will help to provide improved access and more financial security for the poor, but such efforts must be supplemented by improved public health capacity and resource development in poor and underserved areas. A concerted effort that combines expanded insurance coverage with the development of an improved delivery system and strong public health infrastructure is an essential component of reform if we are to improve health outcomes for the poor and vulnerable in our cities.

I thank you for this opportunity to testify. On behalf of the Kaiser Commission on the Future of Medicaid, I look forward to working with you to find and implement solutions to these problems.

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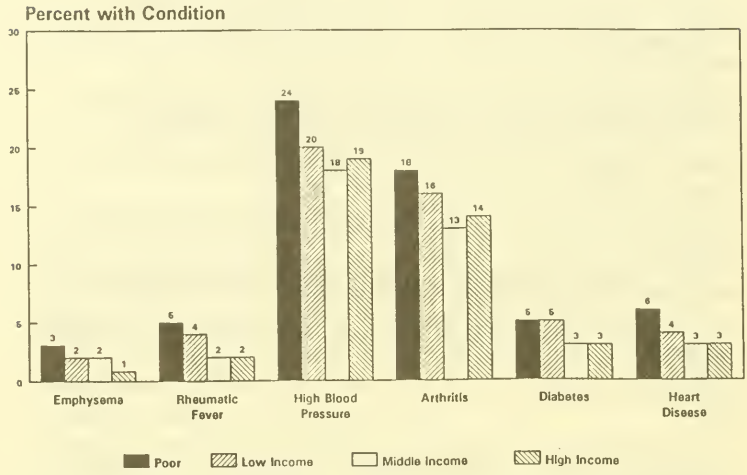
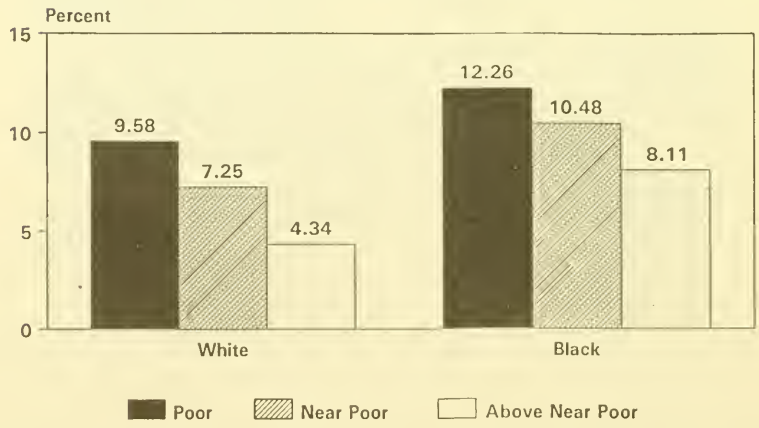
Selected Chronic Health Conditions in Adults Aged 18-64, 1987



Source: NMES, 1987.

Kaiser Commission on the Future of Medicaid

Low Birthweight Percentages by Poverty Status* and Race

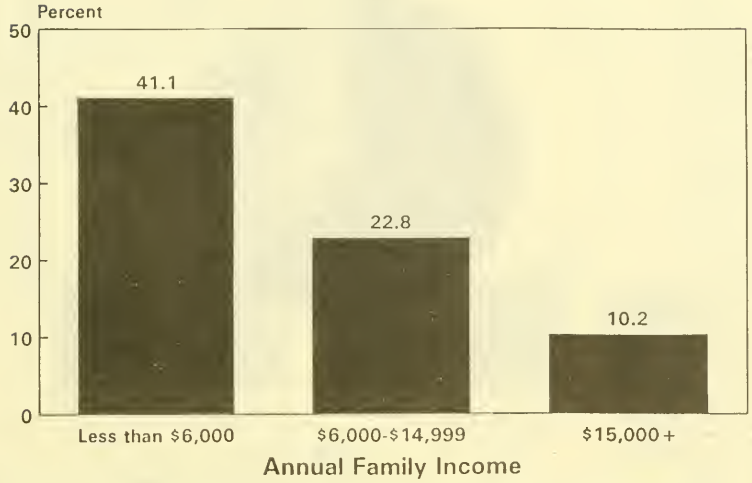


Source: Starfield et al, 1991, from the National Longitudinal Survey of Labor Market Experience of Youth, 1979-1988.

* Economic status of family over course of most of study years.

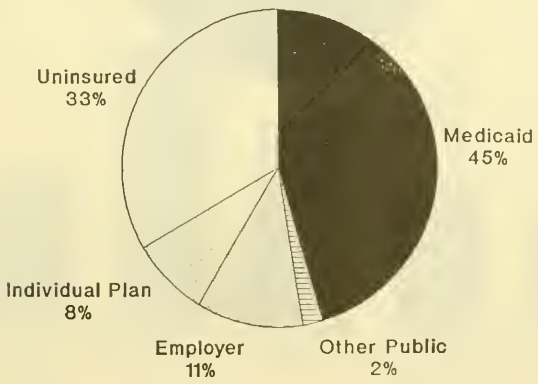
Kaiser Commission on the Future of Medicaid

Percent of Children Aged 6 Months to 5 Years With Lead-Poisoning, 1984



Source: Schwartz and Pitcher, 1986. Kaiser Commission on the Future of Medicaid

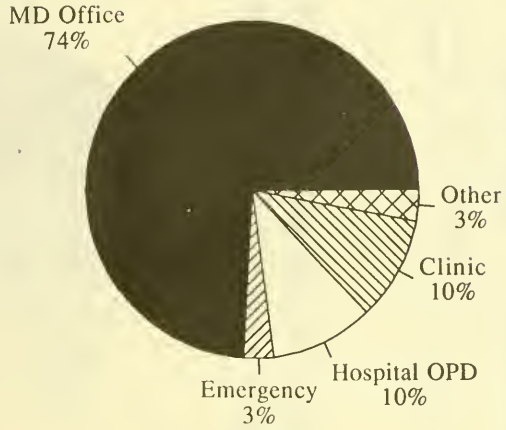
Distribution of Poor Population Under 65 By Insurance, 1991



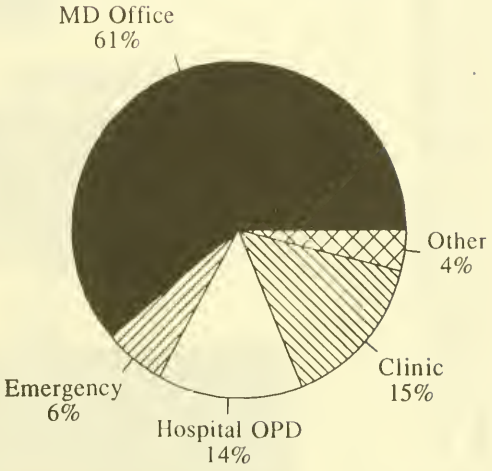
Total = 32.1 million

Source: Current Population Survey, 1992. Kaiser Commission on the Future of Medicaid

Distribution of Medical Contacts for Nonelderly Population, by Poverty Status, 1987



Nonpoor
(200+% of poverty)

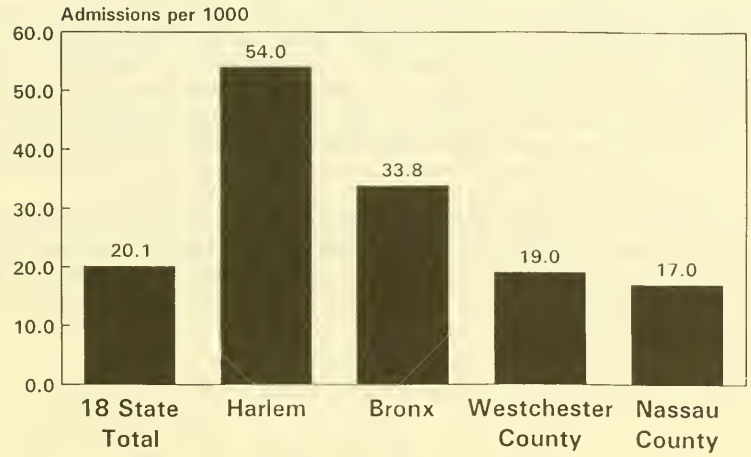


Poor
(Under 100% of poverty)

Source: National Medical Expenditure Survey, 1987

Kaiser Commission on the Future of Medicaid

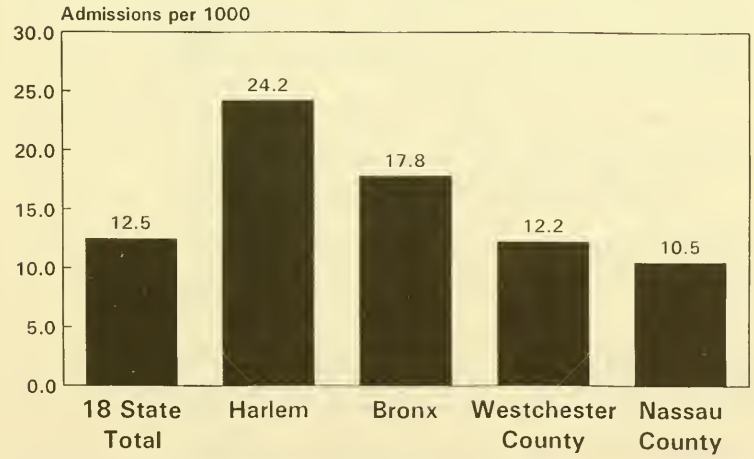
Hospital Admission Rates for Ambulatory Care Sensitive Conditions, 1990



Source: Analysis of the Codman Pandora 18 State Database, 1993.

Kaiser Commission on the Future of Medicaid

Hospital Admission Rates for Trauma, Males 18-24, 1990



Source: Analysis of the Codman Pandora 18 State Database, 1993.

Kaiser Commission on the Future of Medicaid

Chairman RANGEL. Well, I think you also are saying that you also are concerned with the conditions that cause this crisis in the health area, which somewhat Dr. Freeman was talking about.

Ms. ROWLAND. Correct.

Chairman RANGEL. So it may be in your testimony. I may have interrupted too early, but if you could share with us those people who support this, doctors who are not just there to cure people, but doctors and others and educators who should be outraged that they are forced to try to deliver their professional services in this type of environment, so maybe we can have someone to talk with you to see which groups you work with for the longer goal, and that is to make it easier to provide health care to people who don't come into the system in such bad shape.

By unanimous consent the statements, the written statements of all of the witnesses, including Dr. Rosenfield who had to leave, the Dean of the School of Public Health, will be entered into the record.

[Dr. Rosenfield's prepared statement and attachments, as well as responses to questions for the record follow:]

ALLAN ROSENFIELD, M.D.
DEAN
SCHOOL OF PUBLIC HEALTH
COLUMBIA UNIVERSITY

Congressman Rangel and distinguished members of the House Ways and Means Subcommittee on Select Revenues, I am pleased to appear before you today on behalf of Columbia University to discuss Health Care in Underserved America: Implications for National Health Reform. I am currently the Dean of Columbia University's School of Public Health and Professor of Public Health and of Obstetrics and Gynecology. The School of Public Health, in close collaboration with the Harlem Hospital Center has a number of programs of importance to the underserved citizens of Harlem. We are, in addition, involved in major projects in the predominantly Hispanic area of Washington Heights in upper Manhattan.

My testimony today will focus on a recent conference on Urban Health Care held at the Harlem Hospital Center. The aim of the conference (see Attachment A for conference program) was to focus attention on the interacting health and social problems of urban Americans, using Harlem initially as a paradigm for other inner city areas of our country. I would like to review some of the highlights of that meeting, looking specifically at the special needs of inner city populations and the possibilities that many of these needs will not be met by the health care reforms currently being proposed.

Dr. Freeman, the next witness, will eloquently discuss the extent of difficulties in health status in urban communities. I will briefly allude to some of the problems in the inner core of our urban areas. The health problems that I will detail are inextricably connected to the income status of our citizens.

What are some of the problems we see?

o The infant mortality rate in Central Harlem is much higher than comparable rates in other Western countries and, in the U.S., rates for African-Americans are more than twice that of their white counterparts.

o Infectious disease epidemics such as HIV infections, sexually transmitted diseases, measles and tuberculosis are all disproportionately higher among minority populations in the inner city.

o Life expectancy in underserved urban America among African-Americans has decreased, while life expectancy among white Americans has increased.

o The higher incidence of mortality related to breast cancer is more apparent among African-American and Latina women than among white women. There appears to be a direct relationship in this arena to access to both preventive and early curative care.

o Urban citizens demonstrate an increased incidence of mental disorders.

o There has been a significant increase in the number of babies born addicted to cocaine and other substances; at Harlem Hospital, at least 10 % of deliveries are to mothers who use or abuse substances such as cocaine.

o Violence has increased significantly in all cities producing unsafe conditions for many children and other poverty-stricken adults. The number of hospital admissions as a result of gunshot wounds and stabbings has increased significantly over the last decade.

o In 1991, the Office of National Drug Policy noted that there were 26 million Americans reportedly using illicit drugs; 1.8 million were addicted to cocaine, another 700,000 were addicted to heroin. In New York City, some 555,000 individuals abuse drugs, but there are only 43,000 drug treatment slots available.

o Significantly increased death rates in New York City exist for heart disease, cancer, pneumonia, flu, diabetes and cirrhosis.

o Underfunded health facilities, inadequate outmoded facilities, and equipment,

and shortage of personnel contribute to the poor health status in urban areas.

o Higher occupancy rates in hospitals--are a result of boarder babies, lack of elder care and poor housing. Some citizens cannot leave without appropriate living quarters or support services.

Poverty, crime, overcrowded and substandard housing, significant exposure to environmental hazards and limited access to basic health care and social services contribute significantly to the health problems that confront our urban citizens. These problems interact with and in some cases are the cause of the poor health status our urban citizens face.

Dr. Jeffrey Koplan and others from the Centers for Disease Control and Prevention in Atlanta have stressed that there are a number of health challenges in the urban setting that make preventing urban health problems difficult but not insurmountable. These include:

o Increased morbidity and mortality - although methods of prevention are not easily translatable for all conditions, health workers and others must work to encourage seat belt use, safety bars on windows, smoke detectors, gun control and safe playgrounds. The "non-health" items or actions are essential for improving health status.

o Health promotion and disease prevention must be integrated with larger social needs such as employment, housing, education, and increasing development of self worth.

o Methods of preventing disorders must be coordinated within diverse populations.

o The establishment of community partnerships for prevention are of key importance in addressing the many medical and social problems in the cities of America.

Communities have organized a broad array of population-based initiatives such as opposition to billboard advertising of cigarettes and alcohol in the inner city neighborhoods; the development of coalitions to improve the variety of healthy food choices in urban supermarkets, and the establishment of programs on chronic disease prevention in urban areas.

During the course of the Urban Health Conference, Dr. Herbert Nickens, Vice President for Minority Health, Education and Prevention at the Association of American Medical Colleges emphasized, as did many other speakers, that the poor in our country face many obstacles in obtaining care. Many millions are uninsured or under insured, with access to care only as a last resort, through emergency rooms. A number of public health programs have been developed to help improve care such as maternal and child health services; income support services; sexually transmitted disease clinics; substance abuse treatment centers; municipal hospitals for medical care; income support services; and job counseling and retraining programs. Unfortunately, the fragmentation of the systems makes it exceedingly difficult for the poor to negotiate and solve all the problems. Primary care practitioners are urgently needed in the U.S., particularly in the inner city, to assist in improving access to care. One entry point for all systems of care could improve overall care, with case managers to assist in coordinating the care.

Central Harlem specifically, and New York City more generally, epitomize the seriousness of the problems - and present a picture of which this country, one of the world's wealthiest, should indeed be ashamed. As noted by Commissioner Hamburg in her conference presentation, in 1990, a survey of nine low-income neighborhoods in the Bronx, Brooklyn and Manhattan determined that there were only 28 primary care physicians to meet the needs of some 1.7 million residents. Using an index, New York's Health Systems Agency developed a rating scale of each community's health status and found that there were a number of areas where effective primary and preventive services were inadequate-areas they called Health Care Crisis Zones. Some two million New Yorkers resided in these zones. Mr. Gage will later comment on what has happened to our safety net hospitals, but let me just briefly allude to the fact that our public hospital

emergency rooms are grossly overcrowded from both emergency care and primary care.

Even when insurance is not the issue, many citizens living in some of our greatest cities face incredible obstacles to care. A recent survey, conducted by the New York Mayor's Advisory Council on Child Health, sadly documented that less than half of English-speaking uninsured callers trying to get an appointment for prenatal care were able to do so. Only 20 % of Spanish-speaking women were able to arrange such an appointment and only 20% of the callers were assisted by a Spanish-speaking staff person.

Potential Systemic Solutions and Methods of Addressing Change

There is clearly no one way to change the multiple systems our poverty-stricken citizens with ill health face. Some unique efforts and unique suggestions were however made at the conference. Some of the suggestions by speakers were as follows:

o Support the Clinton Administration health care reform efforts to ensure that all Americans have access to care as a right, rather than as, at present, a privilege of those of means.

o Coordinate all systems of care that our citizens from urban core areas face. In California, Dr. Molly Joel Coye, Director of the California Department of Health Services, has developed a "common client-centered budgeting system." Through the system, a low-income mother would be able to detail her history in one location and access welfare and other services elsewhere. Coye calls this the "managed care equivalent in the social service system."

o As a physician, I must stress that, in addition to access, we need to support a broad array of population-based preventive services, including health education, community outreach counselling, disease surveillance and program evaluation. The health care reform effort must include a major emphasis on public health and prevention.

In her speech at the conference, Dr. Karen Davis, Executive Vice President of the Commonwealth Fund, after reiterating the many difficulties apparent in the urban health setting, outlined the implications of health reform for the urban setting. Some of her concerns, and mine, are as follows:

o Major health reform will have a very positive impact on urban areas if it is comprehensive, universal and, has a strong prevention/public health component.

o In urban areas, the benefit package needs to include all appropriate clinical preventive services such as dental care, mental health services, substance abuse services, cancer screening, and family planning services.

o Any thought of abolishing Medicaid should be carefully evaluated. Many of the services under the program fall outside the traditional medical care system.

o Methods of paying providers must be carefully evaluated. Will there be incentives to treat our inner city residents?

o How will the poor be helped to make informed choices about enrollment? Where will the sign-up for enrollment be made? Who will care for the undocumented people, those outside the traditional system who made need care?

o Managed competition or health alliances may not be the appropriate model for inner city populations.

o Methods of ensuring quality standards and for assessing effectiveness of care will need to be developed.

o Who will control Health Purchasing Alliances? Will consumers be represented? Will underserved urban citizens be represented?

o Who will deal with specialized populations such as the developmentally disabled?

Dr. Davis and others have noted that the poor may not fare well in the untested managed competition system. In order to develop a new capacity for care in the underserved communities, facilities and equipment need upgrading and modernizing and the public health system must be supported and expanded.

At the end of the conference, Dr. Lawrence Brown, Professor and Head of the Division of Health Policy and Management at our School of Public Health examined the implications of the conference and of urban health reform. Dr. Brown noted that we are seeing the beginning of a rediscovery and a new recognition of the urban health care problems. However, he is concerned about making an actual policy operational. As Brown has noted, there are simply not enough political representatives and advocates from inner city areas to address these problems in strong coalition form. Our legacy of entitlement programs makes it difficult for us to develop new methods that may be costly initially but save money in the long-run. We need universal affordable health coverage with appropriate cost controls.

Along with these suggestions, others such as Dr. Bruce Vladeck, the Director of HCFA, noted that affordable health insurance is necessary but not sufficient. Entitlement to care does not necessarily equal access. New modes of integration of medical and social services will be needed. We need to understand what contribution the positive aspects of employment make to a person's psyche and to their health and welfare.

SUMMARY

In sum, the Conference has focused once again on the needs and the goals for our urban system. This Committee and others will need to evaluate tax incentives to encourage delivery of care in the urban setting and a true "safety net" for our underserved citizens. As Congress considers the urgently needed reform of the U.S. health care system, the special needs of our inner city populations must be considered. As discussed above, controlling costs and assuring access are clearly high priority, but a population-based, community-oriented preventive perspective is also of the highest priority.

Thank you.

HARLEM HOSPITAL CENTER
AUDITORIUM

HEALTH CARE IN UNDERSERVED URBAN AMERICA: IMPLICATIONS FOR NATIONAL HEALTH REFORM

Sponsor: Columbia University
Hosts: Michael I. Sovern, President, Columbia University
The Honorable Charles B. Rangel, Member of Congress

Monday, June 7

8:00 **REGISTRATION**

8:30 **GREETINGS**

Herbert Pardes, M.D.
Vice President for Health Sciences and
Dean of the Faculty of Medicine,
Columbia University

Bruce Goldman, Executive Director
Harlem Hospital Center

Kevin C. Greenidge, M.D.
President, Manhattan Central Medical Society

Ruth Messinger, President of the Borough of Manhattan

Allan Rosenfield, M.D.
Dean, School of Public Health

HEALTH STATUS OF CENTRAL HARLEM: A Prototype of Inner City America - Indicators of Health Status

MODERATOR: *Gerald Thomson, M.D., Professor of Medicine and Associate Dean, College of Physicians and Surgeons, Columbia University*

9:00 ***The Health of Adults***

Harold Freeman, M.D.
Director of Surgery,
Harlem Hospital Center

Monday, June 7, contd.

9:15 ***Children***

Margaret Heagarty, M.D.
Director of Pediatrics,
Harlem Hospital Center

9:45 *Break*

HEALTH CARE IN INNER CITY AMERICA

MODERATOR: *Mary Mundinger, Dean, School of Nursing, Columbia University*

HARLEM HOSPITAL CENTER
AUDITORIUM

10:00 *A National Problem*
Margaret Hamburg, M.D.
Commissioner, New York City Department of Health

10:30 *The Social, Economic and Human Services Setting*
Molly Coye, M.D., M.P.H.
Director, California Department of Health Services

11:00 *The Special Problems of Substance Abuse*
Herbert Kleber, M.D.
Professor of Psychiatry,
Director, Division on Substance Abuse,
College of Physicians and Surgeons

12:00 *LUNCHEON - HARLEM TEMPLE CORPS, SALVATION ARMY*

Columbia and the City of New York: Health Challenges
President Michael Sovern, Columbia University

The Health of Disadvantaged Urban America: The Challenge and the Imperative
Hon. Charles Rangel, Member of Congress

INNER CITY HEALTH SYSTEMS

MODERATOR: Delores Brisbon, Brisbon & Associates

1:30 *The Contribution of Academic Health Centers to Urban Health Care Delivery*
Herbert Pardes, M.D.,
Vice President for Health Sciences and
Dean of the Faculty of Medicine, Columbia University

1:50 *The Future of Urban Hospitals, Public and Private*
Larry Gage, J.D., President
National Association of Public Hospitals

Kenneth Raske, President, Greater New York Hospital Association

MODERATOR: Dr. Billy Jones, President, Health and Hospitals Corporation

2:20 *Community Based Care Centers*
Fernando A. Guerra, M.D., M.P.H.
Director, San Antonio Metropolitan Health District

2:35 *Managed care and managed competition in the inner city*
Jane E. Sisk, Ph.D.
Professor, School of Public Health
Columbia University

HARLEM HOSPITAL CENTER
AUDITORIUM

3:00	*Practitioners: special problems and needs (matching skills to needs)* *Dr. Herbert Nickens, M.D.* *Vice President, Association of American Medical Colleges*
	Commentator: Dr. Kevin Greenidge
3:30-3:45	*Break*

MODERATOR: David R. Jones, President and CEO, Community Service Society

3:45	*Special Challenge of Prevention in the Inner City* *Jeffrey Koplan, M.D., M.P.H.* *Director, Center for Chronic Disease Prevention and Health Promotion, CDC*
4:15	*Children and Homelessness* *Irwin Redlener, M.D.* *President, NY Children's Health Project*
5:30-7:00	*RECEPTION - SCHOMBURG CENTER FOR RESEARCH IN BLACK CULTURE*

HARLEM HOSPITAL CENTER
AUDITORIUM

Tuesday, June 8

INNER CITY NEEDS AND HEALTH REFORM

MODERATOR:	*Dr. Edward Healton, Associate Dean/ Medical Director, Harlem Hospital Center*
8:30-9:15	**KEYNOTE: NATIONAL PLAN FOR HEALTH REFORM AND THE INNER CITY - BRUCE VLADECK, Ph.D. Administrator, Health Care Financing Administration**
9:30	*Inner City Needs* *Gerald Thomson, M.D.* *Professor of Medicine, Associate Dean,* *College of Physicians and Surgeons*
10:00	*Financing Health Systems in the Inner City* *Karen Davis, Ph.D.* *Executive Vice President* *The Commonwealth Fund*
10:30	*National Health System Reform:* *Proposals and Expectations in Perspective* *Allan Rosenfield, M.D.* *Dean, School of Public Health*
11:00-11:30	*SUMMARY* *Lawrence Brown, Ph.D.* *Professor and Head, Division of* *Health Policy and Management,* *Columbia University*
11:30-12:30	*PRESS CONFERENCE*

Arrangements by: *Harlem Hospital Affiliation Office, C.U.;*
Harlem Hospital Center;
Office of Government Relations and
Community Affairs, C.U.;
Office of Minority Affairs - Health
Sciences Divison, C.U.;
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July 19, 1993

The Honorable Charles D. Rangel
Chairman
Subcommittee on the Select
Revenue Measures
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Rangel:

Thank you for your letter of July 12th. I am sorry that my schedule in New York on the afternoon of your hearing was such that I had to leave. I was looking forward to testifying, but I do understand the problems of hearings when the House is in session.

Let me try to answer as many of the questions as I can.

1) What are the barriers to access faced by many residents of distressed communities?

Clearly, the barriers in inner cities, such as in central Harlem, the south Bronx, parts of Brooklyn, etc., are many. First, there will be those who are the working poor who do not have insurance. Access to care only through an emergency room is poor access, as you well know. But in addition, there are inadequate services available for low-income populations. There are long waiting times even for those who do have Medicaid coverage in overcrowded public hospitals or voluntary hospitals that run public programs. There is inadequate access to immunization services for young children. But also, I think, as you have so eloquently stated on many occasions, the problems in relation to access relate as well to the problems of people living in poverty -- the social disintegration resulting from lack of jobs, poor housing, and the adverse effects of drugs and crime.

2) What are the most significant direct health consequences of the barriers to access faced by residents of distressed communities?

Clearly, the study that Dr. Freeman published with Dr. McCord, and which I believe he discussed in his testimony, has demonstrated the

excess mortality levels in central Harlem, levels that are not found in other inner city populations. And it's not simply from violence and substance abuse. It's related to cardiovascular disease, cancer, and other preventable conditions, in part due to inadequate access to preventive services and to efficient health services when symptoms do strike early on.

3) If universal coverage is achieved in health reform, will residents of distressed communities actually have access to health care?

Yes, to a certain degree, but there continue to be issues well beyond simple access. We need better outreach, better preventive health education, and an improved infrastructure where care can be obtained. All of these things in an inner city are interrelated, and simply improving the financing for access to care for all Americans (as I hope we will do) will not solve all the problems. We need to look at the needed broader public health and preventive interventions.

4) What additional steps beyond issuing everyone a universal health card must we take to address the health problems of residents of distressed communities?

This relates to the earlier questions. We must attempt to make certain that we do have outreach activities, preventive education, assessment capability, etc. In addition, we must ensure that there is sufficient space in the various public clinics, as well as in private doctors' offices, to accommodate patients who would now have insurance.

5) What are the most efficient and effective ways of getting more providers into distressed communities?

It is our hope that the expected health-care reform will, in time, lead to increases in the number of primary-care practitioners, eventually with 50% of all U.S. physicians serving as primary-care providers. We need, I think, to increase the opportunities for national service, in which the loans of so many students could be decreased or even covered for those physicians who spend several years in public service. I also think, as you suggest, that for this and many other reasons, we should attempt to support programs which increase the numbers of minority medical students. This requires not simply opening more slots in medical schools, but also expanded programs at the college level, so that students are better prepared and can compete on an equitable basis with others for entry into medical school.

6) If premature low birth weight babies are one of our most costly problems, what are we doing to prevent their birth?

I don't think the issue is to prevent their birth. I think the issue is, first, through effective family planning programs and reproductive health programs, to attempt to make sure that all pregnancies are wanted pregancies, and then to make certain that prenatal care services are available early for all those who decide to carry their pregnancy to term. There are good data to suggest that those high-risk people, including teenagers, who get into a good prenatal care program and come on a regular basis, do not have a significant increase in risk of low birth weight or premature delivery. Clearly, a reproductive health program must include ready access to contraception, as well as the potential to terminate a pregnancy for those who make that particular decision. For those who do carry their pregnancy to term, we need first-rate, effective prenatal care services readily available without delay.

7) What are the public health implications of the rapid rise in incidence of tuberculosis and AIDS among residents of distressed communities?

Clearly, the AIDS epidemic is one of the most serious and difficult problems of the second half of this century, and the recent increase in cases of tuberculosis, particularly multiple-drug-resistant TB, makes this one of the highest priorities for care in New York City and other inner-city populations. New York City has embarked on an ambitious program in regard to TB and I think we should be supporting programs similar to this on a nationwide basis. There is grossly inadequate funding for TB at the federal level, and this must be changed if we want to contain this epidemic before it becomes worse. The effective control of TB and decrease in the incidence of multiple-drug-resistant TB means that we must put in place direct observed therapy programs and have available, when necessary, programs to institutionalize patients who will not otherwise follow therapy, pretty much along the lines of what's being done in New York City. This is really an essential component of a tuberculosis-control program. Similarly, at the federal level, there is a need for much research. There has really been no research on TB for the last 20 or 30 years. We need new drugs, and new ways to diagnose the disease. The fight against TB must rise much higher on the national agenda.

8) In terms of a broad-based program in which health-care reform is linked carefully to efforts to change the complex social problems of poverty, unemployment, violence, etc.

I don't know of any major examples of programs in this regard. Clearly, a few states like Hawaii and others have attempted to significantly increase access to health care through improved insurance mechanisms. However, I don't know of any large-scale programs that have really focused in ways I think are needed to overcome the problems of poverty, unemployment, and the others that

you list. This ought to be the highest priority for our government, both at state and federal levels, and I have been disappointed by the paucity of major programs in this area.

9) If I had a blank check, what would I do?

If I had a blank check and also Czar-like powers, I would first move to a single-payer system of health care comparable to that in Canada. I would make it a tax-based system with equitable access for all. I would put in place mechanisms to control excess use of high technology and excess numbers of surgical procedures. I would make certain that there were funds for community outreach, preventive education, home care, a strengthened public health infrastructure, and a rational system of long-term care. I would put more money into research on outcomes, so that we have a better idea of what works and what doesn't work. And I clearly would, with enough funds, link these activities with programs to decrease homelessness, to improve housing, and to expand mental health programs to support our mentally ill, who certainly contribute to our homeless problem. I would dramatically increase the funding for treatment, counseling, and support for those using substances, and in this regard I include alcohol and tobacco as well as hard drugs. I wish we had a national commitment to truly embark upon a program to change our current situation. I would add two things: I would probably find a way to ban the National Rifle Association, and I would pass effective legislation on guns. I think it is a travesty that we allow essentially machine guns to be readily available in our country, and hand guns that children can get hold of, leading to terrible morbidity and mortality, not only in our inner cities but elsewhere in our country.

I am sorry that I did not have a chance to discuss this with the Committee at the time of the hearing. Thank you for the opportunity to respond to these questions in writing.

Sincerely,

Allan Rosenfield, MD

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c: Ellen Smith

Dr. Cooper, welcome.

STATEMENT OF ARTHUR COOPER, M.D., DIVISION OF PEDIATRIC SURGERY, HARLEM HOSPITAL CENTER, NEW YORK, N.Y., ON BEHALF OF THE AMERICAN ACADEMY OF PEDIATRICS

Dr. COOPER. Thank you, Congressman Rangel, distinguished members of the subcommittee. My name is Arthur Cooper. I am a pediatric trauma surgeon at Harlem Hospital in New York City.

My colleague, Dr. Harold Freeman, has just shared with you some alarming statistics on the health status of adults within the inner cities of our Nation. My task is to do the same with respect to inner city children, based upon my experience as their surgeon for the past 10 years.

Dr. Freeman has told you that the life expectancy of a man living in central Harlem is shorter than that of a man living in Bangladesh. I will add that the infant mortality rate in central Harlem remains twice the national average. Stated another way, an infant born in Costa Rica or Malaysia has a better chance of celebrating his or her first birthday than an infant born in central Harlem.

The injury mortality rate of children between 1 and 14 years of age in central Harlem is also higher than in other areas, nearly half of which is now due to homicide.

Most of us are now aware that firearm-related violence among adolescent males—particularly among minority populations, who now chiefly constitute the inner cities of our Nation—accounts for the vast majority of these deaths. Former Secretary of Health and Human Services Dr. Louis Sullivan has noted that the leading killer of young black men is young black men. You yourself, Congressman, have noted that we have lost an entire generation of young black men. Such statements are sometimes misconstrued to suggest that violence is somehow inherent to the character of the people most victimized by it. However, through his work on cancer among the poor, Dr. Freeman has shown how race and culture are often viewed as causes of illness, instead of the prism through which the actual causes of illness must be viewed, and in so doing has identified the real culprit, which is neither race nor culture, but the socioeconomic disenfranchisement of the chiefly minority populations of our inner cities.

America's largest socioeconomically disenfranchised minority population, of course, is its children. One-fifth of American children live below the Federal poverty line and one-sixth are without health insurance. Prior to these last several months, during which time it has become possible to believe that some form of national health insurance might become available, we had little reason to hope even for simple justice for poor children whose misfortune it was to be born into families without monetary resources. As important as national health insurance may be, however, it will not by itself ameliorate the desperate living conditions into which many of our Nation's children are born.

The word desperate is derived from the Latin verb desperare, which means to lose hope, and is defined by Webster's Dictionary as reckless or violent because of despair. I have witnessed firsthand the devastating effects of this violence, particularly firearm-

related violence on the bodies and the lives of poor children and their families. I have cared for little children whose brains were blown out by handguns kept in their very own homes, and children whose bodies were ripped apart by assault weapons as they were caught in a crossfire in their very own neighborhoods. And if you do not think your own child or grandchild could be next, I urge you to stop and think again.

This past Memorial Day weekend, driving by my hospital on the way to operate upon a child with appendicitis, I saw a teenage boy shot to death at point blank range, five bullets to his chest, lying crumpled over his bicycle in the middle of Lenox Avenue, not two blocks from Congressman Rangel's own home, a beautiful apartment complex in a lovely neighborhood. Two minutes later I had to open the boy's chest in our emergency department in a vain attempt to save his life. These children didn't choose to be born poor, they didn't choose the color of their skin or their eyes or their hair, and they didn't choose to live in a part of the world where the American dream of life, liberty and the pursuit of happiness was instead a nightmare punctuated regularly by the sound of gunfire and the mournful cries of their friends and families.

They, and we, deserve better, but we must find the courage to say no to those who would hold their constitutional right to keep and bear arms more dear than our children's fundamental rights to life, liberty and the pursuit of happiness, in support of which a Nation was born without which there would be no Constitution. No doubt banning handguns, deadly air guns, and assault weapons, as advocated by the 45,000 fellows of the American Academy of Pediatrics whom I am privileged to represent here today will not stop all the violence, but it will stop most of the death.

Far more of our children will at least then have the chance not to lose hope, but to follow their dreams and ours for them.

Mayor Dinkins of New York City regularly and appropriately reminds us that we Americans are indeed a "gorgeous mosaic." Let us now work together to ensure that this mosaic does not continue to be stained with the blood of our children. Thank you.

Chairman RANGEL. Thank you, Dr. Cooper.

[The prepared statement follows:]

Testimony of the

AMERICAN ACADEMY OF PEDIATRICS

Good afternoon Mr. Chairman, Members of the Subcommittee. My name is Arthur Cooper. I am a pediatric trauma surgeon at Harlem Hospital Center in New York City and a professor of surgery at Columbia University. I am testifying today on behalf of the American Academy of Pediatrics, which represents 45,000 pediatricians dedicated to the health, safety, and well-being of infants, children, adolescents and young adults.

I would like to thank you for this opportunity to share some of the Academy's views on the health and safety issues affecting residents of inner-cities and other distressed areas. This testimony addresses several such issues: gun violence, AIDS, substance abuse, teenage pregnancy, and the shortage of health care providers in the inner cities. My oral remarks, however, will focus on the issue with which I am most intimately acquainted -- gun violence and the harm it wreaks upon American youth generally and inner city youth in particular.

FIREARMS and VIOLENCE

The American Academy of Pediatrics believes that handguns should be eliminated from the environment from which children live and play. We support a ban on handguns, deadly air guns, and assault weapons. As an interim step, we also support the Brady bill and other measures that might help to reduce the availability of these firearms. Although the Academy takes no official position on the various bills to increase taxes on firearms and ammunition, we commend the efforts of Congressman Reynolds and others who are trying to address the terrible problem of gun violence, and its costs to the health care system, through creative proposals.

I speak from personal experience when I tell you that we must do whatever is necessary to stop this senseless slaughter of our nation's children. In the area where I work, homicide is now the leading cause of injury death in children of all ages. I have cared for little children whose brains were blown out by handguns kept in their very own homes, and children whose bodies were ripped apart by assault weapons as they were caught in a crossfire in their very own neighborhoods. And if you do not think you, your spouse, your child, your grandchild, or your neighbor could be next, I urge you to stop and think again: just last week, driving to my hospital to operate on a child with appendicitis, I saw a teenage boy shot to death at point blank range -- five bullets to his chest, lying crumpled over his bicycle in the middle of Lenox Avenue. This occurred not two blocks from Congressman Rangel's own home, an apartment complex in a lovely neighborhood, where not long ago, one of his neighbors, a dentist, was shot to death by a stray bullet while shaving in the morning.

Firearm deaths and injuries are an epidemic that must be stopped, just like any other epidemic that threatens the health of children and the well-being of families. Pediatricians and other health professionals see handguns and assault weapons as pathogens -- agents that cause disease -- just like the polio, measles, or AIDS viruses. And like any other deadly pathogen, these weapons will continue -- inevitably -- to kill and maim until they are eradicated or until our children are provided protection against them.

It is interesting to note that there are about the same number of handguns in this country -- 70 million -- as there are children. Counting other types of guns, there are an estimated 200 million firearms in the United States today. Thus, while shocking, it is not totally surprising that one in six pediatricians reported treating a child wounded by a firearm in 1988.(1) And, by all indications, firearm deaths and injuries have increased since that time. Earlier this year the National Center for Health Statistics (NCHS) reported that the rate of firearm deaths among people age 15 to 19 has climbed to the highest rate ever recorded by the agency, which has been keeping records since the late 1960s. For teens aged 15 to 19, and young adults aged 20-24, firearms are the second leading cause of death (after motor vehicle accidents) -- more fatal than all natural causes combined. Between 1985 and 1990, the rate of firearm deaths for youths aged 15 to 19 rose 77 percent, according to the NCHS study. For black males age 10-14, the rate more than doubled during the same period. These deaths include homicides, suicides and unintentional injuries. Firearms are involved in approximately 70 percent of teen homicides and 63 percent of teen suicides.

Violence does indirect harm as well. Parents, siblings and other relatives suffer permanent emotional damage when a child dies; the community, nation and world lose valuable human potential. Moreover, the witnesses of violence are affected, and children are particularly vulnerable. Children exposed to violence may suffer from the same disorder first identified among Vietnam soldiers -- post-traumatic stress disorder -- which can result in flashbacks, diminished ability to concentrate in school, sleep disturbances, and a fatalistic orientation to the future, which can lead to risk-taking behavior.(2)

A startling number of inner-city children are witnesses to violence. A survey conducted at the Boston City Hospital pediatric primary care clinic found that one in every 10 children attending the clinic had witnessed a shooting or stabbing before the age of 6 years. Half of these occurrences were in the home and half on the streets. Unbelievably, the average age of the children in this study was 2.7 years. Another survey, conducted among elementary school-age children in New Orleans, Louisiana, found that 90 percent of the sample had witnessed violence, 70 percent had seen weapons used, and 40 percent had seen a dead body.(2)

Violence is pervasive in American society. Spouse abuse, child abuse, and school and street violence occur in every type of community among every socioeconomic group. But urban youth are particularly vulnerable. The firearm homicide rate for black and white teenagers (ages 15-19) in metropolitan counties is nearly five times the rate in non-metropolitan counties.(3) In counties containing the primary central city of a Metropolitan Statistical Area (MSA) with a 1980 population of one million or more, the teenage firearm homicide rates are 4 to 6 times higher than in other metropolitan counties.

Moreover, the firearm homicide rate is increasing in urban areas. Non-firearm homicide rates for black and white teenagers generally declined for the 1979-1989 period in both metropolitan and non-metropolitan counties, and firearm homicide rates in all types of counties declined from 1979 through 1984. But, in metropolitan counties the rates increased from 1984 through 1987, and increased rapidly from 1987 to 1989. Firearm homicide rates are highest and increasing the fastest among the black teenage males in metropolitan counties.(3)

These grim statistics represent only the tip of the iceberg. It is estimated that for every child who dies as a result of a gunshot wound, ten more are wounded. Nor are these injuries limited to the nation's largest cities, like New York, Chicago, Philadelphia, Detroit, or Los Angeles. Thirty-four percent of 11th grade students surveyed in half of Seattle's public high schools reported easy access to handguns. Handgun ownership among these students was strongly associated with problem behaviors, but the handguns were not restricted to any one social class or racial/ethnic group, nor restricted to students who reported deviant behaviors.(4)

Handguns account for the majority of teenage firearm deaths and injuries in the United States. Among teenage homicides due to firearms, 73 percent involved handguns, and of teenage suicides due to firearms, 70 percent involved handguns.(5)

A recent survey conducted for the Joyce Foundation by Louis Harris of LH Research found that 77 percent of adults believe that young people's safety is endangered by the widespread presence of guns. One in five parents reported that they have or know someone who has a child wounded or killed by another child who had a gun. One in five parents knows a child "who was so worried that he or she got a gun for self-protection." For African-American parents, that number is one in three. Not incidentally, the survey also showed that, by a margin of 52% to 43%, Americans favor a federal law banning the ownership of all handguns, except by those given permission by a court of law.

The statistics are never-ending. But virtually all point to the same conclusion. **Firearm violence is a public health problem**. It is spreading far too rapidly, and it is killing and rippling large numbers of children, particularly those in the inner city.

When physicians encounter a disease, they look for the causal agent (pathogen) and try to control or eradicate it or protect people from it. In the case of violence in America, the causal agents are numerous and complex. But in the case of one of its offshoots -- firearm violence -- the cause is obvious. The most lethal agent in this disease is the handgun.

The Academy would like to see handguns eliminated from the environment in which children live and play. But, in the meantime, the health care and social service systems must be able to address the disease it causes more effectively:

o High-risk youth can be given follow--up services. Victims of nonfatal firearm injury or other violence are at high risk of becoming fatalities later. Other high-risk youth include those with a history of family or peer violence, substance abuse, depression, previous suicide attempts, or carrying weapons. Health care social service providers should actively intervene in these cases, providing psychosocial assessments, counseling to teens and their families about imminent risk, and home visits or referrals to other support services.

o Schools can establish violence-prevention programs. Although still being evaluated, school curricula aimed at preventing firearm and other violence through coping skills, conflict management, and risk awareness, show promise for reducing the incidence of violence, as there is mounting evidence that violence is a learned response to stress and conflict.

o Research can be conducted. The Academy recommends that active research be undertaken on the precursors and correlates of firearm injuries and on intervention and prevention strategies for children, adolescents, and their families.

Although guns and gun violence are prominently depicted in the media, there are other issues that pose serious health problems for inner city youth, such as HIV-infection, teen pregnancy, sexually transmitted diseases, substance abuse, and a shortage of health care providers. These are discussed below.

HIV INFECTION AND AIDS

The HIV epidemic has spread rapidly among women, children and adolescents in the United States. AIDS has become the leading cause of death for people age 15 to 24. Through March of 1993, 4,480 children, 12,116 young people ages 13-24, and 32,138 adult women have been diagnosed with AIDS. Because the onset of an AIDS-defining illness generally occurs a decade after infection with HIV, these figures greatly understate the total number of persons with HIV in the United States. Approximately 80,000 women and over one million men are estimated to have HIV infection, but are not yet diagnosed with AIDS.

Seventy-nine percent of all women infected with HIV are of childbearing age. More than five out of every six cases of pediatric HIV (87%) have resulted from perinatal transmission, maternal to infant transmission before, during or after birth. Using data from sero-prevalence studies, the CDC also estimates that an additional 1,500 to 2,000 newborns are infected annually due to perinatal transmission. Approximately 45 percent of children with AIDS have been born to women with a history of injecting drug use and the mothers of another 20 percent of children with AIDS became infected through sexual contact with injecting drug users.

Women and children from minority families are disproportionately represented among the ranks of those with HIV infection and AIDS. Fifty-five percent of the reported children with AIDS are of African-American descent, although only about 14 percent of all the nation's children are black. In addition, 24 percent of the children with AIDS have been of Hispanic or Latino origin, although only 11 percent of U.S. children are Hispanic or Latino. Each year at least 40,000 new HIV infections occur among adolescents and adults. Over 19 percent of the reported cases of AIDS in the U.S. are among young adults in the 20-29 age

range. Given the eight to ten year delay between infection and the development of symptoms, most of these young adults were infected during their teen years. However, many were not diagnosed and brought into care until years later.

Each year, an estimated one million adolescents run away from home or are homeless. These adolescents may lack the skills and resources to support themselves and may report to survival sex in exchange for food, shelter, money and drugs. In addition, high rates of sexually transmitted diseases, pregnancy, sexual abuse and rape, alcohol and drug abuse among runaway and homeless youth places these adolescents at very high risk for HIV infection as well.

Experts agree that early intervention is the best strategy to prevent further spread of the virus. It is easier to prevent risky behavior before it starts than to change entrenched behaviors. Preventing infection in women of child-bearing age and preventing conception in women already infected with the HIV virus can stop transmission of HIV from a woman to her fetus or infant. All women and adolescents with, or at-risk for HIV infection, need access to voluntary and comprehensive family planning services offering protection from both unintended pregnancy and transmission of HIV.

For the women and adolescents of low socioeconomic status (often among those most in need), there is little access to preventive health care, family planning, and medical care services, however. In addition, few efforts to control HIV infection have targeted adolescents, who are initiating sexual and drug use activity at younger and younger ages.

Finally, women, children and families affected by HIV disease often have complex needs requiring special care. Although families with HIV come from across the socioeconomic spectrum, many are poor and have limited access to health and social services, transportation and housing. Services for these populations are expensive, and Medicaid, the major financing source, does not reimburse providers of care for all of these services.

To meet the needs of women, children and families affected by HIV/AIDS we must assure an appropriate federal response to the HIV/AIDS epidemic.

PROBLEMS ARISING FROM ADOLESCENT SEXUAL ACTIVITY

Young people mature physically during adolescence, and their capacity and desire to form close and intimate relationships increase. For every young person, these are normal, healthy developments. For some, however, lack of information and foresight, poor judgement, and peer pressure can lead to damaging sexual exploration or exploitation.

Early sexual activity, pregnancy, and childbearing are epidemic in the United States. Currently, over half of women 15-19 years of age have engaged in sexual intercourse at least once. By the age of 19, three-quarters of unmarried women and 86 percent of unmarried men are sexually active. There are two serious consequences to such high rates of sexual activity among our nation's youth: sexually transmitted diseases and teen pregnancy.

Sexually Transmitted Diseases (STDs)

According to the Centers for Disease Control and Prevention (CDC), adolescents and young adults have the highest risk of contracting a sexually transmitted disease. The CDC estimates that 3 million teenagers contract an STD annually. Further, fully one-fourth of all adolescents become infected with a STD before they graduate from high school. Tragically, with the advent of AIDS, the issue of adolescent sexual activity has also become a matter of life or death. The consequences of adolescent risk-taking cannot be overstated. Teenagers and young adults represent the only segment of the United States population for whom mortality has risen over the past quarter century. America lags far behind its peers in Europe and elsewhere with respect to these all-important measurements of social progress.

The rate of adolescent mortality in the United States is the highest in the industrialized world.

Teen Pregnancy

One million adolescent pregnancies occur each year. One-fifth of teenage girls will have one or more babies and one-fifth will have at least one abortion by age 20. Sexually active youth who do not use contraception regularly and effectively are at high risk of becoming pregnant. Research indicates that 40 percent of teenage girls who never practice contraception become pregnant within six months of their first sexual encounter, and two-thirds become pregnant within two years. The health risk for young mothers is greater than it is for adults. And infants born to younger teenagers have a higher rate of mortality by their second birthday than infants of older adolescents and adults. Younger parents, with less education, possible cognitive limitations, a lower socioeconomic level, and little or no support from family, have infants at highest risk for poor development and ill health.

A number of programs with medical and social service support have demonstrated specific strategies that can improve outcomes for infants and parents. These model programs have several elements in common: (1) continuity of care through the prenatal period, labor, deliver, and postpartum follow-up; (2) the delivery of medical, social, and educational services to adolescents; (3) psychological and social services coordinated with medical services; (4) staff members knowledgeable about adolescent development and comfortable in relating to young people; (5) follow-up care for mother and infant including plans for education, vocational training; and (6) easy access to service providers and assistance with child care arrangements, family planning services, and adjustment problems.

Adolescent sexual intercourse and subsequent pregnancy are pressing contemporary concerns. Society can resolve these issues only through open discussion, adequate training of health care personnel, a more effective delivery and funding of health care and health education.

SUBSTANCE ABUSE

Children can be seriously damaged by substance abuse. Additionally, parental substance abuse can do serious damage to families in several ways -- by diverting income; depriving children of their parents' attention; increasing the risk of child abuse and neglect; and increasing the risk that children will become addicts themselves.

Teenagers are easily swayed when it comes to social pressure. This includes slick advertising campaigns that spend many millions of dollars to change attitude and behavior to encourage young people to use alcohol and tobacco products.

Alcohol is the drug most often abused by the largest number of children and adolescents. More than 90 percent have tried alcohol at least once before graduation from high school. In 1991 an estimated eight million junior and senior high school students (40 percent of this population) reported weekly consumption of alcohol, including 5.4 million students who "binged" with five or more drinks in a row and nearly half a million who reported an average weekly consumption of 15 alcoholic drinks. The leading cause of death among Americans 15 to 24 years of age is alcohol-related motor vehicle accidents. Female teenagers who use alcohol while pregnant increase the risk of complications associated with teenage pregnancy as well as risking giving birth to an infant with fetal alcohol syndrome. Young teenagers especially may be unaware of their pregnant state.

Tobacco kills more than 434,000 Americans each year -- more than alcohol, heroin, crack, and airplane accidents, murders, suicides, and AIDS combined. The cost the American public pays is more than $65 billion each year. According to a recent study from the Environmental Protection Agency, three thousand people die each year from second hand smoke and thousands of other children are severely affected through respiratory infections.

The Academy strongly supports increasing taxes on alcohol and tobacco as a means of reducing consumption among children. We also support legislation to limit the dangerous impact of second hand smoke on children by banning smoking in public buildings and all building where children are present.

THE SHORTAGE OF HEALTH CARE PROVIDERS

The Academy believes that every infant, child, adolescent, and young adult should have access to quality, comprehensive medical care, including the provision of preventive care (e.g., immunizations and check-ups); 24-hour assurance of ambulatory and inpatient care for acute illnesses; continuity of care over an extended time period; identification of the need for subspecialty consultation and referrals and appropriate follow-up; interaction with school and community agencies to ensure that any special needs are addressed; and maintenance of a confidential, central medical record and data base with all pertinent medical information about the child. These services are the essential elements of what we call a child's "medical home."

Traditionally, such a medical home has been found in the pediatrician's office. But, if these essential elements are present, a medical home can be found in other settings as well, including hospital outpatient clinics, school-based and school-linked clinics, community health centers, and health department clinics.

Unfortunately, a medical home is unavailable for many inner-city children because there is a shortage of pediatricians and other primary care physicians in their neighborhoods. All too often, children in distressed areas must rely on emergency rooms, walk-in clinics, and other urgent-care facilities that are likely to be less effective, and more costly, than a medical home where a long-standing relationship can be developed between the child, family and caregivers.

The lack of adequate primary care in inner-city areas is due, in part, to the general shortage of primary care physicians in this country. That shortage is thought to be due to perceptions that the work of a primary care physician is more demanding, more stressful, less rewarding, and less well-paying than more specialized practices. The dearth of primary care is compounded in the inner cities due to physicians' concerns about the security of themselves and their families, a high percentage of Medicaid patients for which reimbursement is inadequate, and other factors.

There are several measures that should help to address this physician shortage, including expansion of the National Health Service Corps; development of flexible loan and loan repayment policies to reward students who enter primary care careers and/or establish practices in underserved areas; recruitment and other efforts to increase the number minority primary care physicians, particularly those from inner-city areas; and improved reimbursement rates for primary care services, perhaps with special incentives for physicians serving underserved populations.

SCHOOL HEALTH PROGRAMS

Health education is one of the most effective means of changing health outcomes. Use of tobacco, alcohol, illegal drugs, and sexual activity are all behavioral choices. Comprehensive school health education programs K-12 are the best means of impacting the behavior of our Nation's children. Given the nature of health and education problems today,

education about health is as important as education about math and science. In effect, school health education could immunize our young people against behavioral causes of illness and death. The Academy strongly urges the Congress to advance comprehensive health education programs as an effective means of reducing alcohol, drug, and unsafe sexual activity among our nation's youth.

HEALTH CARE REFORM

All children (from birth through age 21) should have equal access to health care. The Academy believes that a one-tier health care system is essential to achieve this goal. In other words, children who are now uninsured or on Medicaid should be included in the same financing system as all other children; there should be no distinctions based on family income or employment status.

NOTES

(1) Findings from Periodic Survey #3, Gun Control, American Academy of Pediatrics, Department of Research, January 1989.

(2) "Silent Victims: Children Who Witness Violence," Commentary, Journal of the American Medical Association, January 13, 1993.

(3) Lois A. Fingerhut, et al, "Firearm and Nonfirearm Homicide Among Persons 15 through 19 Years of Age: Differences by Level of Urbanization, United States, 1979 through 1989," Journal of the American Medical Association, June 10, 1992.

(4) Charles M. Callahan and Frederick P. Rivara, "Urban High School Youth and Handguns: A School-based Survey," Journal of the American Medical Association, June 10, 1992.

(5) "Firearms and Adolescents," Statement of the American Academy of Pediatrics, published in Pediatrics, April 4, 1992; citing Christoffel and Wintemute (notes 14 and 15).

Chairman RANGEL. Dr. Schenken.

STATEMENT OF JERALD R. SCHENKEN, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. SCHENKEN. Thank you, Mr. Chairman. The AMA is very pleased to be here today to discuss these issues, that is how tax policy can be used to create equity in the health care system, enhance health system reform and raise new revenues to help the most needy and at risk of our inner city patients. Many of the fundamental problems of poverty have been presented with grace and dignity, and I applaud those presentations. However, I think I will focus on the tax and health issues presented in your call for testimony.

The AMA knows that the problem of access to health care for many of our cities is overwhelming. While Federal OBRA mandates have expanded eligibility under Medicaid, too many poor and sick face insurmountable barriers to care due to socioeconomic, educational and language barriers over and above the lack of insurance or public assistance. Over one-third of the 30 million people with family incomes below the Federal poverty line lack health care coverage, either under insurance, Medicaid, or other public aid. Forty percent of those eligible for Medicaid still receive no benefits from this program, primarily because of lack of access to primary care physicians and clinics in their areas.

Administrative hassles, high urban practice costs, disincentives for primary care and personal safety concerns are all factors that deter physicians from inner city practice. Further, few Federal incentives exist to encourage medical students to choose primary care specialties and to practice in these underserved areas. These cities lack primary care facilities, leading to costly reliance on emergency rooms and poor followup care, and you have heard many, many examples. This vicious cycle continues with poor patient education and lack of prevention, continued costly and high tech interventions, and tragic though avoidable outcomes.

Less than 5 years ago some 83 percent of the 181 tuberculosis patients discharged from the Harlem Hospital in New York City did not continue treatment due in great part to lack of access to followup care. For these reasons the AMA supports the use of tax incentives to encourage physicians to practice in inner city areas as well as underserved rural areas. To keep physicians practicing in the inner city, we advocate Federal support for the education and training of primary care physicians, reauthorizations of programs under title 7 of the Public Health Service Act, and increased funding to promote recruitment and retention of participants in the National Health Service Corps, perhaps through better repayment of opportunities, loans, and scholarships.

One important note, Mr. Chairman, regardless of what plan we have for long-term health care reform, we must give immediate support to our inner city hospitals, such as the Harlem Hospital in your district and the New Orleans Charity Hospital where I worked for 10 years and which I continue to support through Tulane University.

These venerable institutions are often our only safety net for millions of our less fortunate. Mr. Chairman, we also support excise

taxes on tobacco, alcohol, and firearms, products which are dangerous and harmful to our patients, and which generate staggering health care costs. The details are in our longer statement. Billions of dollars are spent each year treating these conditions. The costs are preventable, and we believe that increased tax to deter their use will save not only costs but lives.

The AMA is opposed to provider taxes which place a discriminatory burden on health care professionals who, unlike the inherently dangerous products described above, are connected to the health care system because they want to save lives. Physicians, nurses, and other professionals should not be singled out unfairly. If taxes must be imposed on individuals rather than products that kill and maim, they should be equitable, broad-based, and nondiscriminatory.

Let me close, Mr. Chairman, by mentioning our AMA major initiative on violence. For several years we have worked to raise the sensitivity of physicians and the public to that scourge that violence inflicts upon our people and its massive costs in money and lives. We have initiated a nationwide series of educational seminars, media and editorial board conferences, reports of our AMA councils and testimony before committees of Congress. We thank you for giving us this opportunity to bring this critical issue to the table. Mr. Chairman, we look forward to working with you and your committee as we enter this new decade of health system reform, and we hope greatly improved access to care to our inner city patients. Thank you.

[The prepared statement follows:]

Statement

of the

American Medical Association

to the

Subcommittee on Select Revenue Measures

Committee on Ways and Means

U.S. House of Representatives

Re: Tax Issues Affecting Inner City Health Care

Presented by: Jerald R. Schenken, MD

June 29, 1993

Mr. Chairman and Members of the Subcommittee:

My name is Jerald R. Schenken. I am a physician from Omaha, Nebraska and am also a member of the AMA Board of Trustees. I am pleased to be here today to testify on behalf of the AMA and our 300,000 physician members on a number of health-related tax issues, including those that affect the health care and safety of our inner city patients.

Access to Care Issues

The AMA recognizes that the problems of access to health care for many living in the inner city are far-ranging and complex. While federal mandates under OBRA 1987 and 1989 have expanded access through broadening Medicaid eligibility standards, too many of the poor and sick still face nearly insurmountable barriers to health care due to socioeconomic, educational, cultural and language barriers, as well as lack of protection for health care expenses from either the public or private sectors.

One-third of the 30 million people with family incomes below poverty lack health care protection under either Medicaid or other plans. Moreover, even when patients are aware of their ability to receive care under Medicaid, a substantial number are precluded from getting basic necessary and preventive care due to the lack of physicians and primary care facilities in inner city areas. Inadequate and untimely reimbursement, administrative hassles, high urban practice costs, professional isolation, and fears for personal safety are all factors that deter physicians from practicing in underserved inner city areas and medical students from choosing primary care specialties with a public service orientation. Similarly, inner city health systems generally consist of public and teaching hospitals which specialize in the delivery of emergency services and tertiary care. Primary care health facilities in the inner-city are almost non-existent. Few community health clinics exist and free-standing physician offices are ever-decreasing. Even the highest risk inner-city patients often have limited access to the health care system, except in emergencies. In 1988, 83% of 181 people discharged with tuberculosis from New York City's Harlem Hospital were lost to follow-up care and did not continue treatment.

Other poor, inner-city residents suffer from a variety of illnesses that do not require emergency treatment, but do need early detection and routine care in order to avoid catastrophic complications and more expensive care. Hypertension, diabetes, coronary artery disease, and sexually transmitted diseases, including asymptomatic HIV infection, all too often go undetected until they become advanced. The high cost and lack of coverage for prescription drugs further impede preventive and maintenance measures.

Despite the great need for physicians to provide primary care to patients in the inner cities, historically the number of physicians who have chosen this mission has remained low, for all the reasons discussed above. A proposal to roll the current Medicaid population into a health plan for the uninsured may increase the potential availability of physicians for underserved patients, but without physicians practicing in their neighborhoods, or in accessible areas, many inner city residents will still be disenfranchised from health care unless they can maintain an ongoing relationship with a physician committed to their care. Regardless of what occurs under health system reform, support for free-

standing physician offices and clinics in underserved areas is critical to ensuring that the needs of these patients will be met cost-effectively. To that end, the AMA supports the use of tax incentives and credits to encourage physicians to practice in inner-city areas, as well as underserved rural areas. A primary care physician, who has long practiced in an underserved area of Detroit, serving a patient population that is 80% reimbursed by Medicaid, spoke at a recent AMA meeting to explain that without some kind of tax relief or government assistance soon, she would no longer be able to continue her mission of care to the inner city poor due to the economic strain of paying $40,000 a year for professional liability insurance, coupled with practice costs. We cannot afford to lose any of these dedicated doctors. Tax incentives to keep quality physicians practicing in underserved areas will enhance any health reform system by serving several important goals. Tax relief will help to preserve and promote free-standing physician offices and clinics in the inner cities; it will help offset the income differential that discourages many physicians and medical students from seeking to practice in inner cities; and will allow poor patients the same choice of care that wealthier patients now enjoy -- a physician practicing in a setting familiar to them who is also familiar with their health care needs and lifestyle.

We believe tax incentives should also be considered as part of an overall strategy to encourage medical students and physicians to work in underserved areas. Negative sanctions or mandates to force increases in primary care physician forces will not work. But positive incentives should be explored and maximized to ensure that the emerging challenge of major health system reform can be met. To achieve that goal, increasing funding and training of primary care physicians must become a national priority. Federal and state governments should develop incentives, such as appropriate deductions of loan payment, and deferring or forgiving loan repayments for medical education (as is now done under the National Health Service Corps (NHSC)), to encourage practice in underserved areas. Medical schools should be provided incentives to develop training programs to affiliate with community hospitals and ambulatory settings. Concomitantly, federal support for the education and training of primary care physicians, under reauthorization of programs under Title VII of the Public Health Service Act, and more funding to promote recruitment and retention of participation in the NHSC must continue, as well as strengthening the NHSC's ability to address inner-city needs by encouraging the NHSC to earmark a certain percentage of its repayment opportunities, loans and scholarships for underserved inner-city facilities.

These strategies represent only a few approaches to improving access to health care in inner cities. The AMA two weeks ago sponsored a well-attended national conference on improving access to underserved areas. The conference examined a number of urban and rural programs which have proved successful in expanding care and strengthening linkages in existing health systems. We will continue to support these programs, as well as promote awareness of the strides that can be made when health care providers work together to find creative solutions to the often seemingly overwhelming barriers to health care access in inner cities.

Mr. Chairman, the AMA recognizes that to significantly improve access to care for our patients who live in the underserved inner city with its complex and often tragic health care needs requires a special and concentrated involvement. To that end, we would like to work with you and other members of the Subcommittee to develop a health care "Peace Corps" to help expand health care services to the inner city. We have worked with members of the urban and rural caucuses on these issues; today we reiterate our commitment as physicians to advance a program that will not only advance health system reform, but more personally involve physicians in this historic process.

Tax Incentives to Advance Health System Reform

Mr. Chairman, the AMA recognizes also that simply increasing and retaining the ability of physicians to practice in inner city areas alone will not adequately address the compelling health care needs of a majority of inner city residents, many of whom live at extreme risk every day. To combat the existing inequalities, the 28.3 million urban residents who comprise more than three-fourths of the nation's 37 million uninsured must have universal access to care. The AMA proposal for achieving this goal is set forth in Health Access America, a health reform proposal that shares many similarities with reform measures being considered now by this Administration. Our proposal would require employers to insure all employees and their families, and would expand Medicaid, or a similar federal/state program, to cover everyone below the federal poverty level.

We advocate a uniform standard benefits package, which we recently described at an April 22, 1993 hearing before the House Ways and Means Committee Subcommittee on Health. We believe our health benefits package, which was recently approved by our House of Delegates at our annual

meeting just two weeks ago, represents a momentous step forward in assuring universal, cost-effective coverage, and better access to preventive care. Our benefits package is designed to reflect the typical benefits offered in many current health policies -- including the benefits available under the Federal Employees Health Benefits Program -- by offering a wide range of services, including mental health benefits and hospice care. Our benefits package is also affordable. AMA actuarial consultants have estimated the cost of this package at an average cost of $2,700 per employee, based on the national average mix of individual as well as family coverage.

The standard benefit package's affordability and viability will, however, be predicated in part on its tax treatment. Tax deductibility -- linked to the standard benefits package -- will be critical to achieving comprehensive reform, along with other provisions to ensure predictability and equity, such as community rating and ERISA modifications to require self-insured plans to meet federal standards. The inner city patient, like all patients, needs to be offered more empowerment and control in their health care decision making. Such involvement, encouraged by tax and similar incentives, can help the patient make better and more cost-effective health care decisions, regardless of what program is providing the coverage. To that end, the tax treatment of employee health care benefits should be altered to reward prudent health care insurance choices. Such incentives should include consideration of:

- capping the amount of employer-provided health insurance that is tax-exempt at an appropriate ceiling of the geographically-adjusted costs of the standard benefits package (a move that could raise revenues to fund expanded access for the uninsured by billions over a five year period, based on CBO estimates of tax caps on deductibility of $250 per month for family coverage and $100 per month for individual coverage);

- allowing employees to deduct any health care coverage amounts paid out of pocket, with a cap on insurance deductibility, depending on income;

- providing tax-free rebates to employees who select less costly insurance plans.

Other tax help for employers, employees, family care-givers and small businesses must also be employed if health reform is to succeed. The AMA supports a number of tax incentives to enhance health system reform, including:

- providing a federal sliding scale tax credit for small businesses whose premiums for the standard benefits package exceed a designated percentage of payroll/wages and a designated percentage of before-tax income;

- extending an additional tax benefit to all new businesses (such as a 150% deduction for insurance premium costs during the first year of operation); and

- increasing the 25% temporary income tax-deduction for health insurance paid by the self-employed to 100% and making that deduction permanent.

Tax incentives should also be strongly considered for advancing the nation's current lack of adequate funding and resources for long-term care. The Internal Revenue Code should be amended to allow employers and individuals to deduct long-term care insurance costs as well as standard health insurance costs. Tax deductions or credits should be used to support family care-giving, and sliding scale subsidies should be provided for the purchase of long-term care insurance for individuals with incomes between 100% and 200% of federal poverty. The tax code should be changed to allow individuals to deduct 100% of the cost of long-term care insurance premiums without meeting the 7% floor for health costs or the 2% floor for miscellaneous deductions. Similarly, the tax code should allow for penalty-free and tax-free withdrawals from individual retirement accounts (IRAs) for the purchase of long-term care insurance. Mr. Chairman, the AMA supports these tax initiatives as equitable incentives that will improve funding for and access to health care.

Provider Taxes

In contrast, the AMA is opposed to the financing of health system reform or Medicaid plans through provider taxes. Provider taxes are inequitable and illogical. They unfairly and disproportionately penalize health care professionals simply because they are connected with the health care system. No other profession, even those that are highly compensated, is so often distinguished for tax purposes. Taxes imposed on individuals should be equitable, broadbased and non-discriminatory, i.e. applied to

the population more generally rather than unfairly singling out certain professions.

Excise Taxes on Tobacco, Alcohol and Firearms

The AMA also has clear policy supporting increases in excise taxes on products which are dangerous and potentially harmful to the health of individuals, with revenue generated to be allocated to health care needs. We recommend, as one alternative, that revenues generated from taxes on harmful products be used to assist low-income working Americans struggling to pay out-of-pocket health care expenses, such as insurance premiums, co-insurance and deductibles. We support taxes on all products harmful to life and health, including tobacco, alcohol and firearms -- all of which are major contributors to health care costs in this country. Billions of dollars are spent each year treating medical conditions that could be avoided. Violence, drugs, alcohol and tobacco are wreaking havoc on our health systems. These are preventable costs, and increasing excise taxes on inherently dangerous products will achieve not only cost savings, but will save lives as well.

To help achieve both these savings goals, the AMA has tenaciously increased public and physician awareness of tobacco's ill-health effects throughout the years. The AMA was instrumental in studying and exposing the link between cigarette smoking and death and disease. The AMA pointed out unequivocal evidence that, among other dangers, cigarette smoking is the most significantly modifiable risk factor for coronary heart disease. The AMA has and will continue to highlight the mortality and morbidity caused by tobacco products, including smoking as a major cause of stroke, a cause of lung cancer in healthy non-smokers, and a cause of fetal injury, prematurity and low birthweight. As the primary contributing cause of death in more than 434,000 Americans each year, tobacco costs our nation more than $65 billion annually in related health care expenditures and lost productivity. Canada's example dramatically demonstrates that raising the price of cigarettes greatly decreases consumption.

According to the Congressional Joint Committee on Taxation, increasing the federal excise tax on cigarettes would raise $54 billion over the next five years. The AMA strongly favors increasing the federal excise tax on cigarettes, and specifically supports an increase in federal excise taxes for tobacco and alcohol which would be allocated to health care needs and health education.

Recent data on alcohol abuse and alcoholism indicates that 100,000 deaths and $85.5 billion annually in health care costs are associated with abuse of alcohol. Moreover, some studies project that some 25 to 40 percent of patients in general hospital beds are being treated for complications of alcoholism. Alcohol abuse, like cigarette smoking, disproportionately adversely affects the poor due to lack of access to preventive care, lack of education and other socioeconomic factors that promote risky behavior. This abuse also causes deleterious outcomes, including birth defects caused by alcohol consumed during pregnancy, drunk driving injuries and fatalities, and adverse, even lethal reactions, induced when drinking is combined with tranquilizers, painkillers, sedatives, and over-the-counter drugs. Accordingly, AMA policy supports tax increases for alcohol, as well as tobacco products, with the additional revenues directed to the Medicare Hospital Insurance Trust Fund.

In addition to the reprehensible effects of tobacco and alcohol abuse on the most vulnerable of our patients, the most serious, deadly, costly, and all-too unfortunately escalating, national health care threat in American society today is violence. It has reached epidemic proportions, constituting a major medical and public health issue. Violence within the family and society is an enormous public health problem, particularly when that violence is associated with the use of firearms. The widespread and easy availability of firearms is a significant factor in the escalating violence problem. To comprehend the magnitude of the problem, we need search no further than the fact that, from 1960 to 1980, the population of the United States increased by 26%; but during this same time period, the homicide rate due to guns increased 160%.

Family and so-called "intimate" assaults involving firearms are at least 12 times more likely to result in death than such family assaults involving all other types of weapons. Experts estimate that as many as 100,000 school-aged children carry guns with them to school each day. Finally, hospital costs related to firearm injuries add an estimated $429 million to health care costs each year. When costs for ambulance services, physician services, rehabilitation, and long-term care are included, total medical expenditures for firearm injuries reach an estimated $1 billion per year. These horrifying statistics alone justify the proposal to increase the excise tax on handguns to 20 percent and all other firearms to 22 percent, with 50 percent of total revenue generated to be deposited in a fund dedicated to the health care needs of the victims of this violence. The AMA supports this tax.

Many urban hospitals do incur substantial costs as a result of treating uninsured shooting victims. We believe that these funds should be available to all affected parties providing this essential care, including hospitals, providers of rehabilitative services, physicians and others in both urban and rural areas. While urban needs are obvious, the escalation of firearm injuries also is seen in rural areas.

Mr. Chairman, the issue of imposing a tax for three years (1997-1999) on needle devices that the Food and Drug Administration determines to be unsafe does pose several concerns for us. First of all, even if a particular needle device is considered "unsafe," it may be perfectly safe and acceptable for use under certain circumstances and for certain medical purposes/procedures. Other mechanisms such as Occupational Safety and Health Administration regulations and prudent judgments based on liability concerns currently exist to address the problem. We simply do not believe that imposition of a federal tax on needle devices, which would most likely be passed on to the consumer with true medical needs thereby increasing health care costs, is a necessary or desirable approach.

Miscellaneous Tax Issues

The AMA would like to comment briefly also, Mr. Chairman, on several other miscellaneous tax issues raised by this Subcommittee. On the issue of treatment of HMOs and risk pools under Section 501(m) of the Internal Revenue Code, the AMA believes that special federal tax incentives should continue to be offered under 501(m) to ensure that companies which offer insurance to charitable recipients at lower than market costs should enjoy universal tax benefits. States have encouraged insurance assistance for charitable and low income recipients through Good Samaritan laws. Federal tax assistance provides a better and more equitable incentive to provide lower cost insurance to a needy population.

The AMA endorses a proposal to encourage organ donations through the inclusion of donor information on Federal Department of Treasury materials that would be sent to every taxpayer. The problem of significant shortages of viable organs for donation continues to be a national health care tragedy. We support this and other proposals to encourage awareness of the donation process.

The AMA supports the efforts of the Physician Insurance Association of America (PIAA) and other groups to amend federal tax revenue rules so that physician insurers do not face the current burden imposed by new discounting guidelines under Revenue Rule 92-76 that have resulted in a much higher tax burden on these generally small companies. The intent of the Tax Act of 1986 was that companies should be taxed on their economic income (100%). Current revenue rules, which do not fully take into consideration discounting factors for claims made policies, should be amended to provide relief for these companies and ensure that they are not paying more than 100% tax on their economic income. These companies were formed during the liability insurance crisis of the late 1970s when many commercial carriers abandoned the market.

Finally, Mr. Chairman, the AMA seeks your support to reverse a proposed tax directive set out in Section 14212 of the H.R. 2264, the budget reconciliation bill. That proposed section would lower the amount of compensation that can be taken into account under a tax-qualified pension plan from $235,840 to $150,000. The new pension rules will make it extremely difficult for urban not-for-profit clinics to compete with more lucrative for-profit groups for the most talented physicians. Section 14212, if it stands, will affect disproportionately the non-profit institutions, which predominate in the health care industry. The result will be adverse consequences to the pension benefits of the employees of these not-for-profit entities.

Under this section not-for-profit organizations, which are already severely limited in their ability to provide deferred compensation packages, will be impeded further. Section 457 of the IRC limits deferred compensation for non-profits to a maximum of $7,500 per year. Furthermore, the use of even this limited deferred compensation arrangement negates the ability to use a tax deferred annuity. The maximum TDA allowed is $9,500 a year. Private, for-profit groups are not subject to these limitations.

The effect of this proposal will be to encourage physician groups to avoid not-for-profit status, and organize instead as corporations or partnerships. Those groups that remain non-profit will be greatly disadvantaged in recruiting top physicians because of these pension limitations. This result will also have a detrimental impact on health system reform, as most experts have endorsed the salaried, not-for-profit group practice as the model to be used in reform.

Mr. Chairman, we respectfully ask you to consider our concern regarding these new proposed pension rules, as well as the other tax positions we have discussed above. Health system reform is a complex process, which we have expended great time and effort to advance in recent years. The momentum to achieve equity and the difficult transitions to massive health system reform will require careful consideration of tax implications. We pledge to help you in reaching the goal of reform through fair, consistent and prudent tax applications in our rapidly evolving health market system.

Chairman RANGEL. Thank you, Dr. Schenken. My questions to you will not be as a doctor from Nebraska, but rather in your role as a member of the board of trustees for the American Medical Association. One of the problems that we have, say, with our teachers union, at least I have, is that whenever their contract comes up they are concerned about tenure and sabbaticals and pensions and work week and those things which they think the unions are designed to protect them; increase their benefit. Yet we have an ever increasing number of high school dropouts. And sometimes you look at it and you wonder why the teachers and the profession don't explain why the dropouts are so high in particular communities and they don't really include in their contract negotiations the type of support that is necessary for them to actually do what they have been trained to do, to teach and and to be disciplinarians and not to defend themselves against criminal assaults and not to have to fight parents, but really to teach. But, it is never an issue.

The product they get is never an issue. Now, we say we have to support the hospitals located in our inner city. Of course we do because they are overworked and they provide a service and we have to give them all the money that we can, so we will be hearing from the hospital people. But as relates to the American Medical Association, it is your people that is teaching in these—that are working, rather, in these hospitals. You know the conditions that they work under. You know that they are heroes and heroines who don't just care about the time. You have heard the testimony which shares the depth of their commitment to issues that go far beyond just trying to repair and patch up people, and yet we see the high mortality rates that cause people to lose faith in the very hospital which is the health care institution of first and last resort.

My question appreciates that doctors know that they are almost as unpopular in this Nation as Congress people are and that whenever we have a health care crisis and we find the cost of health care going up that when the cuts come the first thing politically that is going to be looked at is the reimbursement to hospital and the reimbursement to doctors. Why fight these battles one by one. Why not take up the leadership and say we would not have the problems we face today, the exodus of specialists, the exodus of doctors from the inner cities if you would at least help us to have just regular patients rather than the disasters and the near death cases that we are involved in. So, again, I would like to preface my remarks not to a committed doctor from Nebraska. But I have been here 23 years, and I never remember hearing formally or informally the American Medical Association saying, my God, what do you expect of us when people are coming from us and living in conditions that are worse than Third World nations? We expect more of our doctors than we did medics during the time of war.

Dr. SCHENKEN. Well, Mr. Chairman, fortunately most, although maybe organized medicine and Congress may have an edgy reputation, most people like their own congressmen, and most people like their own doctor so I think there is perhaps some hope for both of us.

Chairman RANGEL. Well, our problem here is that most of the people we are talking about don't have their own doctors.

Dr. SCHENKEN. I think you made a good point, and I would have to admit that we probably have not done as good a job as we should in this regard.

Chairman RANGEL. And I would like to point out that in the area of cigarettes at great risk you have moved in the area of preventive care and pointing out the dangers of smoking.

Dr. SCHENKEN. Yes, as Mr. Hoagland will confirm, I joined with a Democrat to try to raise the cigarette tax in Nebraska, and in another hat that I wear, that was at some political risk to me, because I believe in it.

Chairman RANGEL. The AMA really went out there against another powerful industry and took them on.

Dr. SCHENKEN. Mr. Chairman, we internally have a tremendous number of internal policies and so forth that address these issues, but let me give you one which we have addressed externally, and I think we have not done as good a job of publicizing it as we should. On the issue of infant mortality, we have taken a look at that very carefully and found, as many other people have, that probably 80 percent, you can get some flexibility depending on your assumption, of the reasons for infant mortality have absolutely nothing to do with medical care and have everything to do with poverty, with drugs, with education, and so forth, but beyond that, the association is a small association, and what we can do is say that you have got to do that.

As far as infant——

Chairman RANGEL. Having said that, what is the limit on what a small association——

Dr. SCHENKEN. Well, in other words, to me that is a problem for the country.

Chairman RANGEL. I am talking about the American, the United States of America Medical Association, that is all I am talking about because you are on the board. I am not talking about what a chapter or a State or local, all I am saying is that you are 100 percent correct. I go around this country and look at these little babies that are the size of my hand for whom we are spending billions of dollars of taxpayers' money to keep them alive. We know that many of them will be burdens and have unproductive lives in our society. Yet, we still are going to have to continue to pay. While I recognize that it gives doctors a tremendous experience in how to handle these low weight babies, I can see the pain that they have in them coming in day after day, tending to these babies abandoned by their parents and left there in the intensive care wards.

I am asking what have I missed that the AMA has said about what is happening to the health care in America in these areas that we are talking about today?

Dr. SCHENKEN. Well, I think in fairness to the AMA, Mr. Chairman, we have spent a lot of time. I have done it myself, and all of my trustees, friends have been doing it, and so have the State medical associations, going around the country, talking about the problems of drugs, the problems of violence, the problems of socioeconomic implication. Immunizations, for example, at a quick blush it looks like maybe poverty is a problem with immunizations, but we have studied it and really it has to do with the access of the people to the clinics and their willingness to get their babies immu-

nized, so I think in part if we have a problem, it is we have not publicized our efforts well enough, but I am proud of our efforts in these areas. Perhaps we should do a better job just publicizing them.

Chairman RANGEL. Let me say this: There is hardly a lack of presence of the AMA in your Nation's capital and in this House of Representatives. I can assure you whatever shortcomings you may think that the AMA has, its support or nonsupport of legislation is clearly known by every Member of the House and every Member of the Senate and our staffs, and so you are well organized. And for them to be unable to get their message out, that is going to be hard to understand because they know how to get their message out.

I just hope that we can include—expand the message as to what you are doing in the areas that you were talking about, and I want to work with you. I just hope you would say what else more can we do and then we can pick it up from there.

Dr. SCHENKEN. We would certainly be glad to do that, but I think in fairness, Mr. Chairman, just in the 50 or more up here times I have appeared, I have talked about drug abuse, I have talked about violence, I have talked about education, myself, all of these things.

Chairman RANGEL. For the AMA or for yourself?

Dr. SCHENKEN. For the AMA. I have represented the AMA many times, and as I say maybe we haven't done as good a job selling it, but it is not for lack of trying.

Chairman RANGEL. Well, if you can share with me what you have done, I will tell you that I will use all the resources I have to pass that on to my colleagues.

Dr. SCHENKEN. Thank you, sir.

Chairman RANGEL. Mrs. Rowland, I think we have a contract, that your testimony makes it clear where you are coming from. Help us to identify, and include, of course, the American Medical Association, and other people that are working with you that understand the problem. Perhaps if we all pick up just a little bit we can get this thing focused. And, Dr. Cooper, I have not heard more eloquent testimony. You have identified where I live, and you also have said that it is next to the emergency ward of Harlem Hospital and also next to the local fire station, and if I had a problem of sleeping, my God, it would really be bad. But, thank you for hanging tough with your profession, your expertise, and bringing that to our Harlem Hospital, but more importantly, thank you for your commitment.

This is what I was talking about, Dr. Schenken. Not just developing his expertise in repairing these little babies after they have been assaulted upon, but to say why do we constantly have to do this. That is all I am talking about. I think the Congress has been derelict by not having taken on the responsibility of investing up front in order to prevent the tremendous costs that we are facing today in health care so that even getting to the hospital may mean that you are there too late. So I hope it wasn't a criticism. It is just an effort to see what vehicles of cooperation are available and how can we better use them, and I thank the three of you.

Mr. Hoagland.

Mr. HOAGLAND. No questions.

Chairman RANGEL. Mr. McNulty.

We thank this panel, and Congressman McNulty will chair the meetings—the next panel, rather.

Dr. SCHENKEN. Thank you, Mr. Chairman, and definitely in the spirit in which it was given, I appreciate your comments.

Chairman RANGEL. Well, I look forward to working with you.

Mr. MCNULTY [presiding]. I would like to welcome the members of panel number three, and we will begin with Commissioner Marilyn Krueger, representing the National Association of Counties.

STATEMENT OF HON. MARILYN A. KRUEGER, COMMISSIONER, ST. LOUIS COUNTY, MINN., AND CHAIR, HEALTH STEERING COMMITTEE, NATIONAL ASSOCIATION OF COUNTIES

Ms. KRUEGER. Thank you, Mr. Chairman, subcommittee members, I am Marilyn Krueger, chair of the St. Louis County Board of Commissioners in Minnesota and chair of the National Association of Counties Health Steering Committee. Thank you for this opportunity to testify.

My remarks today will focus on the tax exempt status of nonprofit hospitals. We believe that there are some inner city residents who are not receiving appropriate services because some nonprofit facilities are not providing charity care.

I want to give you a context for our concern. In most areas of the country, the county government is the form of government responsible for the uninsured. Counties in 36 States bear part of the legal responsibility. In 17 of those States, counties bear the sole responsibility. This holds true in most major urban areas as well. The public hospitals in Chicago, Los Angeles, Miami, and Atlanta, to name just a few, are all heavily supported by county taxes.

Our traditional safety net role also includes county appropriations to the non-Federal share of Medicaid in 20 States, the operation of 4,500 health facilities, including 581 hospitals and over 2,000 public health departments, and a responsibility for spending over $30 billion annually on health and hospitals. This commitment to health services has made it the largest line item for the average county budget, now at 17 percent.

Due to a variety of pressures, our focus on enhancing the provision of charity care by nonprofit entities has become more intense over the past 10 years. We are assuming increasing responsibilities due to a diminished Federal role and State budget pressures.

Counties in the 1980s had a 105 percent real increase in health and hospital expenditures. We have responded by making the tough and unpopular decisions to raise revenues and cut other services. Last year over 80 percent of urban counties raised revenues, primarily through property taxes, and three-quarters of them expect to do it again next year.

Because of the shrinking governmental resources, all elected officials are examining more closely than ever the spending of taxpayer dollars or the loss of revenues through tax subsidies. The General Accounting Office in 1990 estimated a $4.5 billion annual Federal subsidy to nonprofit hospitals. The questions for many local elected officials have become: Are tax exempt hospitals truly

helping relieve local governments of a portion of the burden of providing health care to those who cannot afford it? Are we getting our money's worth?

During the search for revenues under health reform, these same questions should be asked by the Federal Government. In 1990 the General Accounting Office released a report urging Congress to revise the current criteria for tax exemption if it wants hospitals to focus more closely on charity care. One year later, a public citizen report on patient dumping shed light on the inequitable distribution of charity care.

In 1989, 1990 and 1991 NACO was the only national organization to testify in support of much stronger charity care measures. Despite the lack of Federal legislation, there has been progress on this issue which ultimately helps inner city residents. Increased attention has been given to the issue by the American Hospital Association and the Catholic Hospital Association. AHA has raised some tough questions on how marketing and mission is often blurred.

These questions included: Is it ethical to capture a market by driving another provider out of business when this results in a certain population no longer being served? Since most hospitals do not market to the poor, is marketing activity often a kind of discrimination aggravating the problem of access? Are the programs and services of not-for-profit hospitals driven by community needs or their own institutional self-interest?

The State of Texas has been a leader in this issue. Four weeks ago the Governor of Texas signed the first State legislation to more clearly define and regulate the duty of nonprofit hospitals to provide community benefits, including charity care. There are a number of options available to a hospital to meet its community benefit requirement. A plan and annual report will be submitted annually. Measures include charity care and government-sponsored care equal to at least 4 percent of the hospital's net patient revenue or similar care in an amount equal to 100 percent of the hospital's tax exempt benefits, excluding Federal income tax.

In Utah, three counties last week filed an appeal now pending before the Utah Supreme Court. The counties have argued that the nonprofit hospitals in question have consistently provided nominal indigent care, often amounting to less than 1 percent of their gross revenues, while they have large operating profits and growing reserves.

Finally, some tangible good developments on charity care have occurred in Lehigh County, Pa. A few years ago the county and the nonprofit hospitals were in court. They negotiated an out-of-court nonfinancial agreement in which the hospitals have agreed to provide the bulk of health services for the county's jail population. This includes an agreed-upon number of free patient days, drugs purchased by the county at the hospital's lower rate, and outpatient services.

To conclude, NACO believes that a variety of changes will have to take place before counties stop disputing the tax status of some hospitals. Congress should reconsider previous legislation proposed by former Representatives Donnelly and Roybal and examine the framework designed by the Texas legislation. In short, charity care

must be a central mission of a nonprofit hospital. By no means would stronger charity care measures solve all health access problems for inner city residents, but it would force those hospitals which have blurred their original mission to serve anyone needing care in the community. Thank you. I look forward to responding to questions.

Mr. MCNULTY. Thank you very much, Commissioner.

[The prepared statement follows:]

STATEMENT OF MARILYN A. KRUEGER, COMMISSIONER, ST. LOUIS COUNTY, MINNESOTA, AND CHAIR, HEALTH STEERING COMMITTEE, NATIONAL ASSOCIATION OF COUNTIES

MR. CHAIRMAN, SUBCOMMITTEE MEMBERS, I AM MARILYN KRUEGER, CHAIR OF THE ST. LOUIS COUNTY (MN) BOARD OF COMMISSIONERS AND CHAIR OF THE NACo HEALTH STEERING COMMITTEE. THANK YOU FOR THIS OPPORTUNITY TO TESTIFY.

MY REMARKS TODAY WILL FOCUS ON THE TAX EXEMPT STATUS OF NON-PROFIT HOSPITALS. WE BELIEVE THAT THERE ARE SOME INNER CITY RESIDENTS WHO ARE NOT RECEIVING APPROPRIATE SERVICES BECAUSE SOME NON-PROFIT FACILITIES ARE NOT PROVIDING CHARITY CARE.

I WANT TO GIVE YOU A CONTEXT FOR OUR CONCERN. IN MOST AREAS OF THE COUNTRY, THE COUNTY GOVERNMENT IS THE FORM OF GOVERNMENT RESPONSIBLE FOR THE UNINSURED. COUNTIES IN THIRTY-SIX STATES BEAR PART OF THE LEGAL RESPONSIBILITY. IN SEVENTEEN OF THOSE STATES, COUNTIES BEAR THE SOLE RESPONSIBILITY. THIS HOLDS TRUE IN MOST MAJOR URBAN AREAS AS WELL. THE PUBLIC HOSPITALS IN CHICAGO, LOS ANGELES, MIAMI AND ATLANTA, TO NAME JUST A FEW, ARE ALL HEAVILY SUPPORTED BY COUNTY TAXES.

OUR TRADITIONAL SAFETY NET ROLE ALSO INCLUDES COUNTY APPROPRIATIONS TO THE NON-FEDERAL SHARE OF MEDICAID IN TWENTY STATES; THE OPERATION OF 4,500 HEALTH FACILITIES, INCLUDING 581 HOSPITALS AND OVER 2,000 PUBLIC HEALTH DEPARTMENTS; AND A RESPONSIBILITY FOR SPENDING OVER $30 BILLION ANNUALLY ON HEALTH AND HOSPITALS. THIS COMMITMENT TO HEALTH SERVICES HAS MADE IT THE LARGEST LINE ITEM FOR THE AVERAGE COUNTY BUDGET, NOW AT 17 PERCENT.

DUE TO A VARIETY OF PRESSURES, OUR FOCUS ON ENHANCING THE PROVISION OF CHARITY CARE BY NON-PROFIT ENTITIES HAS BECOME MORE INTENSE OVER THE PAST TEN YEARS. WE ARE ASSUMING INCREASING RESPONSIBILITIES DUE TO A DIMINISHED FEDERAL ROLE AND STATE BUDGET PRESSURES.

COUNTIES IN THE 1980'S HAD A 105 PERCENT REAL INCREASE IN HEALTH AND HOSPITAL EXPENDITURES. WE HAVE RESPONDED BY MAKING THE TOUGH AND UNPOPULAR DECISIONS TO RAISE REVENUES AND CUT OTHER SERVICES. LAST YEAR, OVER 80 PERCENT OF URBAN COUNTIES RAISED REVENUES -- PRIMARILY THROUGH PROPERTY TAXES -- AND THREE-QUARTERS OF THEM EXPECT TO DO IT AGAIN NEXT YEAR.

A NUMBER OF OTHER PRESSURES ARE ADDED TO THIS MIX WHICH HAS CAUSED A NUMBER OF COUNTIES TO TAKE LEGAL ACTION AGAINST NON-PROFIT HOSPITALS. DOUBLE DIGIT MEDICAL INFLATION; MILLIONS OF UNINSURED; HOSPITALS PARTICIPATING IN AN INCREASINGLY COMPETITIVE MARKET TO EXPAND THEIR SHARE OF PATIENTS, WITH MANY CLOSING THEIR EMERGENCY ROOMS; STATES IMPOSING TAXING LIMITS ON LOCAL GOVERNMENTS; AND COURT CASES CONSISTENTLY ENFORCING COUNTY OBLIGATIONS TO PROVIDE INDIGENT CARE. ALL OF THESE FACTORS MAKE IT VERY CHALLENGING TO BE A LOCAL ELECTED OFFICIAL. THE HEALTH NEEDS OF INNER CITY RESIDENTS AND OVERALL BUDGET PRESSURES ARE WITH US DAILY.

BECAUSE OF THE SHRINKING GOVERNMENTAL RESOURCES, ALL ELECTED OFFICIALS ARE EXAMINING MORE CLOSELY THAN EVER THE SPENDING OF TAXPAYER DOLLARS OR THE LOSS OF REVENUES THROUGH TAX SUBSIDIES. THE GENERAL ACCOUNTING OFFICE IN 1990, ESTIMATED A $4.5 BILLION FEDERAL SUBSIDY TO NON-PROFIT HOSPITALS. COUNTY GOVERNMENTS ACROSS THE COUNTRY ARE ALSO WEIGHING THE REVENUES LOST FROM PROPERTY TAX EXEMPTION VERSUS THE BENEFITS RECEIVED

* The National Association of Counties is the only national organization representing county government in the United States. Through its membership, urban, suburban and rural counties join together to build effective, responsive county government. The goals of the organization are to: improve county government; serve as the national spokesman for county government; serve as a liaison between the nation's counties and other levels of government; achieve public understanding of the role of counties in the federal system.

FROM NON-PROFIT HOSPITALS. THE QUESTIONS FOR MANY LOCAL ELECTED OFFICIALS HAVE BECOME, "ARE TAX EXEMPT HOSPITALS TRULY HELPING RELIEVE LOCAL GOVERNMENTS OF A PORTION OF THE BURDEN OF PROVIDING HEALTH CARE TO THOSE WHO CANNOT AFFORD IT? ARE WE GETTING OUR MONEY'S WORTH?" DURING THE SEARCH FOR REVENUES UNDER HEALTH REFORM, THESE SAME QUESTIONS SHOULD BE ASKED BY THE FEDERAL GOVERNMENT.

THESE PRESSURES AND EXPERIENCES WITH SOME NON-PROFIT HOSPITALS HAVE LEAD US TO SUPPORT STRONGER CHARITY CARE MEASURES AS ONE OF A VARIETY OF MEASURES TO DISTRIBUTE SOME OF THE BURDEN OF UNCOMPENSATED CARE. AS OF LAST FALL, AT LEAST ONE NON-PROFIT HOSPITAL IN THIRTY-TWO STATES HAD THEIR TAX EXEMPT STATUS CHALLENGED.

OUR SUPPORT FOR HEALTH REFORM ASSUMES THAT IN A TRULY REFORMED SYSTEM, THIS WILL NO LONGER BE AN ISSUE. BUT, UNTIL THAT TIME, OUR INNER CITY RESIDENTS WOULD BE BETTER SERVED BY A STRONGER NON-PROFIT HOSPITAL COMMITMENT TO THEM.

SOME BRIEF BACKGROUND ON TAX EXEMPTION MAY BE HELPFUL.

PRIOR TO 1969, IN ORDER TO BE EXEMPT FROM FEDERAL INCOME TAX AS A CHARITABLE ORGANIZATION, A HOSPITAL WAS REQUIRED TO ACCEPT PATIENTS "NOT ABLE TO PAY FOR THE SERVICES RENDERED AND NOT EXCLUSIVELY FOR THOSE WHO ARE ABLE AND EXPECT TO PAY." IN 1969, THIS RULE WAS CHANGED SIGNIFICANTLY BY THE INTERNAL REVENUE SERVICE, ASSERTING THAT THE PROVISION OF HEALTH CARE WAS IN ITSELF A CHARITABLE PURPOSE AND DID NOT NECESSARILY REQUIRE CARE TO THE INDIGENT. IRS ADOPTED A "COMMUNITY BENEFITS" STANDARD AND DROPPED SPECIFIC REFERENCE TO CHARITY CARE. AT THAT POINT, MANY POLICY MAKERS BELIEVED THE NEW MEDICARE AND MEDICAID PROGRAMS WOULD FINANCE MUCH OF THE PROVISION OF CHARITY CARE. IN 1983, AN IRS REVENUE RULING EXTENDED TAX EXEMPTION TO A HOSPITAL THAT DID NOT HAVE AN EMERGENCY ROOM -- THE PRIMARY POINT OF ACCESS FOR MANY INDIGENT INDIVIDUALS.

IN 1990, THE GENERAL ACCOUNTING OFFICE RELEASED A REPORT URGING CONGRESS TO REVISE THE CURRENT CRITERIA FOR TAX EXEMPTION IF IT WANTS HOSPITALS TO FOCUS MORE CLOSELY ON CHARITY CARE. WE WERE NOT SURPRISED THAT A SIGNIFICANT NUMBER OF HOSPITALS FAILED TO PROVIDE CHARITY CARE EQUAL TO THE VALUE OF THEIR FEDERAL TAX EXEMPTION, LET ALONE THEIR STATE AND LOCAL BENEFITS. WE WERE ALSO NOT SURPRISED TO LEARN THAT MANY OF THE "COMMUNITY BENEFITS" HOSPITALS PROVIDED WERE AVAILABLE FOR A FEE AND WERE NOT TARGETED AS A WHOLE AT LOW INCOME INDIVIDUALS, NOR DID THEY HAVE PROACTIVE GOALS AND POLICIES ON INDIGENT CARE.

ONE YEAR LATER, A PUBLIC CITIZEN REPORT ON PATIENT DUMPING SHED LIGHT ON THE INEQUITABLE DISTRIBUTION OF CHARITY CARE. IN 1986, CONGRESS OUTLAWED PATIENT DUMPING IN THOSE HOSPITALS RECEIVING MEDICARE AND PROVIDING EMERGENCY SERVICES. DESPITE THE LAW, THE REPORT FOUND THAT AN ESTIMATED 250,000 PATIENTS WERE DUMPED EACH YEAR. YET, ONLY A HANDFUL OF HOSPITALS WERE ACTUALLY FINED OR SANCTIONED. ONLY THIRTEEN HOSPITALS RECEIVED CIVIL FINES AND THE MAJORITY OF THE SETTLEMENTS INCLUDED AGREEMENTS THAT THE DUMPING VIOLATIONS WOULD NOT BE MADE PUBLIC. THE REPORT, BASED ON THE CASES INVESTIGATED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, CONCLUDES THAT THE CHIEF MOTIVE FOR "DUMPING" PATIENTS IS TO AVOID CARING FOR THE POOR. THE PROBLEM IS EXACERBATED BY THE CLOSING OF EMERGENCY ROOMS, TOO OFTEN THE FIRST POINT OF ACCESS FOR THE INDIGENT.

IN 1989, 1990, AND 1991, NACo WAS THE ONLY NATIONAL ORGANIZATION TO TESTIFY IN SUPPORT OF MUCH STRONGER CHARITY CARE MEASURES. WE WERE PLEASED BY THE IRS REVISED AUDIT GUIDELINES RELEASED LAST YEAR TO PROVIDE EXAMINERS WITH CLEARER INSTRUCTIONS FOR REVIEWING INCREASINGLY COMPLEX CHARITABLE ENTITIES. WE SUPPORT THEIR RE-FOCUSED EFFORTS TO REQUEST GREATER DETAIL ON EMERGENCY ROOMS, MEDICAID, MEDICARE AND CHARITY POLICIES.

DESPITE THE LACK OF FEDERAL LEGISLATION, THERE HAS BEEN PROGRESS ON THIS ISSUE WHICH ULTIMATELY HELPS INNER CITY RESIDENTS.

INCREASED ATTENTION HAS BEEN GIVEN TO THE ISSUE BY THE AMERICAN HOSPITAL ASSOCIATION AND THE CATHOLIC HOSPITAL ASSOCIATION. WHILE WE HAVE VERY DISTINCT DIFFERENCES OVER WHAT TYPES OF COMMUNITY BENEFITS TRULY DESERVE THE PRIVILEGE OF QUALIFYING FOR TAX EXEMPTION, BOTH ASSOCIATIONS HAVE HIGHLIGHTED THE ISSUE. AHA HAS RAISED SOME TOUGH QUESTIONS ON HOW MARKETING AND MISSION IS OFTEN BLURRED. THOSE QUESTIONS INCLUDED: IS IT ETHICAL TO "CAPTURE A MARKET" BY DRIVING ANOTHER PROVIDER OUT OF BUSINESS WHEN THIS RESULTS IN A CERTAIN POPULATION NO LONGER BEING SERVED? IS THE MONEY SPENT ON AN EXPENSIVE ADVERTISING CAMPAIGN JUSTIFIED, OR COULD IT BE BETTER SPENT ON HOME CARE FOR THE ELDERLY OR ON NURSES' SALARIES? SINCE MOST HOSPITALS DO NOT MARKET TO THE POOR, IS MARKETING ACTIVITY OFTEN A KIND OF DISCRIMINATION, AGGRAVATING THE PROBLEM OF ACCESS? IS IT FINANCIALLY RESPONSIBLE FOR HOSPITALS TO ENGAGE IN A MEDICAL "ARMS RACE" THAT LEADS TO A WASTEFUL ESCALATION OF COSTS? ARE THE PROGRAMS AND SERVICES OF NOT-FOR-PROFIT HOSPITALS DRIVEN BY COMMUNITY NEEDS OR THEIR OWN INSTITUTIONAL SELF-INTEREST?

WE WELCOMED THE CATHOLIC HOSPITAL ASSOCIATION'S EFFORTS TO DEVELOP "SOCIAL ACCOUNTABILITY BUDGETS." THESE QUESTIONS AND GUIDELINES ARE EXACTLY THE TYPES OF EFFORTS LOCAL ELECTED OFFICIALS WOULD LIKE TO HAVE ANSWERED AND ACTED UPON BY HOSPITALS IN THEIR COMMUNITIES.

DESPITE SOME RECENT PROGRESS, THERE ARE STILL A NUMBER OF COUNTIES IN A NUMBER OF STATES WHO QUESTION WHETHER THE VALUE OF THE TAX EXEMPTIONS RECEIVED AND ABILITY TO BENEFIT FROM TAX EXEMPT BONDS BY NON-PROFIT HOSPITALS IS GIVEN BACK TO TRULY MEET THE NEEDS OF THE COMMUNITY IT SERVES.

WITH THE CURRENT CRISIS IN THE PUBLIC HEALTH CARE SYSTEM COMPOUNDED BY AIDS AND DRUG ABUSE, THE INCREASE IN UNINSURED AND UNDERINSURED INDIVIDUALS, AND FINANCIAL CONSTRAINTS AT ALL LEVELS OF GOVERNMENT, SERVING THIS POPULATION IN INNER CITIES SHOULD BE A PRIORITY FOR THOSE ENGAGED IN THE PROVISION OF HEALTH CARE IN THE CHARITABLE SECTOR.

IRS TESTIMONY TWO WEEKS AGO BEFORE THE WAYS AND MEANS OVERSIGHT SUBCOMMITTEE AND RECENT ACTIVITY IN TEXAS AND UTAH DEMONSTRATE THAT THIS IS STILL A SERIOUS ISSUE.

ACCORDING TO THE IRS, THEY ARE CURRENTLY INVESTIGATING TWENTY-ONE HOSPITAL CASES WHICH RAISE QUESTIONS WHETHER THERE IS NON-COMPLIANCE. RECENT CASES INCLUDED REVOCATION OF A HOSPITAL'S EXEMPTION BECAUSE ITS BOARD ESTABLISHED A NEW FOR-PROFIT CORPORATION WHICH "BOUGHT" THE HOSPITAL AND THEN RESOLD IT AT A PRIVATE GAIN OF $2.3 MILLION TO EACH OF THE BOARD'S DIRECTORS. JOINT VENTURES AND EXCESSIVE COMPENSATION LEVELS HAVE ALSO BEEN A CONCERN TO THE IRS. THEY CAUTIONED THE SUBCOMMITTEE THAT:

> "THE ADMINISTRATION OF THE LAWS AFFECTING PUBLIC CHARITIES PRESENTS DIFFICULT CHALLENGES FOR THE INTERNAL REVENUE SERVICE. THE STANDARDS GOVERNING TAX EXEMPTION ARE IMPRECISE. MOREOVER, THE SOLE SANCTION FOR VIOLATION OF THESE STANDARDS IS REVOCATION OF EXEMPTION. EFFECTIVE ADMINISTRATION OF THESE LAWS IS PARTICULARLY IMPORTANT, HOWEVER, BECAUSE OF THE VALUABLE SUBSIDIES GRANTED TO PUBLIC CHARITIES IN THE FORM OF TAX EXEMPTIONS AND THE ELIGIBILITY TO RECEIVE TAX-DEDUCTIBLE CONTRIBUTIONS."

THE STATE OF TEXAS HAS BEEN A LEADER IN THIS ISSUE. FOUR WEEKS AGO, THE GOVERNOR SIGNED THE FIRST STATE LEGISLATION TO MORE CLEARLY DEFINE AND REGULATE THE DUTY OF NON-PROFIT HOSPITALS TO PROVIDE COMMUNITY BENEFITS, INCLUDING CHARITY CARE. THERE ARE

A NUMBER OF OPTIONS AVAILABLE TO A HOSPITAL TO MEET ITS COMMUNITY BENEFIT REQUIREMENT. A PLAN AND ANNUAL REPORT WILL BE SUBMITTED ANNUALLY. MEASURES INCLUDE CHARITY CARE AND GOVERNMENT SPONSORED CARE EQUAL TO AT LEAST FOUR PERCENT OF THE HOSPITAL'S NET PATIENT REVENUE; OR SIMILAR CARE IN AN AMOUNT EQUAL TO 100 PERCENT OF THE HOSPITALS' TAX EXEMPT BENEFITS, EXCLUDING FEDERAL INCOME TAX. MOST NON-PROFIT HOSPITALS IN TEXAS ARE PROVIDING SOME CHARITY CARE, BUT ACCORDING TO 1989 DATA, ABOUT 47 PERCENT OF ALL HOSPITAL BEDS WERE IN NON-PROFIT HOSPITALS BUT NON-PROFITS WERE ONLY PROVIDING 31 PERCENT OF ALL UNCOMPENSATED CARE. SOME HOSPITALS WERE PROVIDING LITTLE TO NO CHARITY CARE. THIS LANDMARK STATE LEGISLATION IS A STRONG STEP TOWARD ENSURING THAT ALL RESIDENTS RECEIVE CARE.

IN UTAH, THREE COUNTIES LAST WEEK FILED AN APPEAL NOW PENDING BEFORE THE UTAH SUPREME COURT. WHILE THE APPEAL OF COURSE REVOLVES AROUND POINTS OF LAW, THE COUNTIES HAVE ARGUED THAT THE NON-PROFIT HOSPITALS IN QUESTION HAVE CONSISTENTLY PROVIDED NOMINAL INDIGENT CARE, OFTEN AMOUNTING TO LESS THAN ONE PERCENT OF THEIR GROSS REVENUES, WHILE THEY HAVE LARGE OPERATING PROFITS AND GROWING RESERVES. THEY HAVE ARGUED THAT THESE HOSPITALS' OPERATIONS ARE INDISTINGUISHABLE FROM THEIR FOR-PROFIT COMPETITORS. THE COUNTIES ALSO ARGUE THAT THE HOSPITALS DO NOT MEET THE UTAH SUPREME COURT'S PREVIOUS RULING THAT A GIFT TO A COMMUNITY CAN BE IDENTIFIED BY THE LESSENING OF A GOVERNMENT BURDEN THROUGH THE CHARITY'S OPERATION.

FINALLY, SOME TANGIBLE GOOD DEVELOPMENTS ON CHARITY CARE HAVE OCCURRED IN LEHIGH COUNTY, PENNSYLVANIA. A FEW YEARS AGO, THE COUNTY AND THE NON-PROFIT HOSPITALS WERE IN COURT. THEY NEGOTIATED AN OUT-OF-COURT, NON-FINANCIAL AGREEMENT IN WHICH THE HOSPITALS HAVE AGREED TO PROVIDE A BULK OF HEALTH SERVICES FOR THE COUNTY'S JAIL POPULATION. THIS INCLUDES AN AGREED UPON NUMBER OF FREE INPATIENT DAYS, DRUGS PURCHASED BY THE COUNTY AT THE HOSPITAL'S LOWER PRICE, OUTPATIENT SERVICES, PSYCHIATRIC BEDS AND DRUG/URINALYSIS TESTING FOR THE WORKERS IN THE COUNTY'S LONG TERM CARE FACILITY. THE COUNTY HAS BEEN PLEASED WITH THIS SETTLEMENT.

TO CONCLUDE, NACo BELIEVES THAT A VARIETY OF CHANGES WILL HAVE TO TAKE PLACE BEFORE COUNTIES STOP DISPUTING THE TAX STATUS OF SOME OF THEIR HOSPITALS: 1) ANTI-PATIENT DUMPING LAWS MUST BE VIGOROUSLY ENFORCED; 2) THE IRS ENFORCEMENT MUST SHOW CHANGES IN THE INSTITUTIONAL BEHAVIOR OF SOME NON-PROFIT HOSPITALS; 3) HOSPITALS MUST BE ABLE TO ANSWER THE TOUGH QUESTIONS THEIR ASSOCIATIONS ARE ENCOURAGING THEM TO ASK; AND 4) FEDERAL LEGISLATION MUST PROVIDE THAT CHARITY CARE SHOULD BE A CENTRAL MISSION OF A HOSPITAL. CONGRESS SHOULD RECONSIDER PREVIOUS LEGISLATION PROPOSED BY FORMER REPRESENTATIVES DONNELLY AND ROYBAL AND EXAMINE THE FRAMEWORK DESIGNED BY THE TEXAS LEGISLATION. IN SHORT, CHARITY CARE MUST BE A CENTRAL MISSION OF A NON-PROFIT HOSPITAL.

BY NO MEANS WOULD STRONGER CHARITY CARE MEASURES SOLVE ALL HEALTH ACCESS PROBLEMS OF INNER CITY RESIDENTS. BUT IT WOULD FORCE THOSE HOSPITALS WHICH HAVE BLURRED THEIR ORIGINAL MISSION TO SERVE ANYONE NEEDING CARE IN THE COMMUNITY.

THANK YOU. I LOOK FORWARD TO RESPONDING TO QUESTIONS.

Mr. MCNULTY. Next we will hear from John Martinez who is the executive director of the New York State Medical Care Facilities Finance Agency.

John.

STATEMENT OF JOHN G. MARTINEZ, EXECUTIVE DIRECTOR, NEW YORK STATE MEDICAL CARE FACILITIES FINANCE AGENCY

Mr. MARTINEZ. Mr. Chairman, members of the committee, as you indicated, my name is John Martinez, and I am executive director of the New York State Medical Care Facilities Finance Agency. I want to thank you for the opportunity to appear before you today to discuss how current tax law impacts on our ability to provide low cost access to capital for health care providers in the inner city through the use of tax exempt financing.

As you know, New York State has the oldest health care system in the country. Additionally, New York has a major concentration of health care clients in the New York City metropolitan area. The combined need for modernization, expansion, and continued refinement of that system, coupled with the dramatic demand for appropriate, affordable quality health care has led to the increased need for capital market access. The MCFFA, in our capacity as a public benefit corporation, has issued in excess of $9 billion of tax exempt bonds and expect in the next 18 months to exceed $2 billion of additional financing. However, despite the significant volume, we do not find it possible to provide capital access for some of the most important and neediest borrowers, the primary care providers which we often know as community health centers.

Under the Tax Code the 501(c)(3) institutions which normally set up community health centers are allowed to access the tax exempt market under the Federal Tax Code. This access substantially reduces the cost of borrowing which are eventually included in the health care charges that are passed along to consumers and the health care reimbursement system. These institutions, however, must use a third party conduit on their behalf in the borrowing process. Often that conduit is like an entity such as MCFFA. One of the tools that is available is the private placement of bonds with bank lenders which represents an opportunity to provide access to capital, but there is one glitch.

Using local lenders you must have a small issue as defined under the Tax Code, and a small issue under the current provisions means that you cannot have issued more than or expect to issue more than $10 million in a current year. That means that in New York where you have a large statewide issuer like MCFFA, you will not have access to the bank lending opportunity because an issuer on a statewide basis will always issue more than $10 million in bonds. The current tax law regarding bank eligibility for small bond issues precludes many of New York's smaller health care institutions from placing those bonds because of that $10 million cap.

This restriction also will limit their ability to move forward where there are no other issuers available to them such as in the New York metropolitan city area. We are suggesting that as an alternative it would be appropriate to change the current bank eligibility exemption from a $10 million limit per issuer to a $5 million

limit per borrower. I think it is important to note that State issuers like MCFFA possess the expertise needed to evaluate the availability of potential projects and design tax exempt offerings which meet industry standards for safety and soundness.

They have a staff of qualified finance experts who can assist in selecting the appropriate financing option, negotiate covenants and confirm pricing for each financing. They help to standardize the process. Many local issuers lack such expertise and potentially cause harmful consequences for the borrower and the investing public. To penalize small health care institutions for using a large conduit issuer such as in New York, the MCFFA, will deprive them from accessing what may be the best or only plan of finance available—direct bank lending.

Since New York plans to undertake a major initiative to approve community health care centers throughout the State, the use of direct placement with local lenders would be a very helpful tool. We then respectfully request consideration be given to provide a small borrower test, not a small issuer test. The limitation in this case should be $5 million per borrower rather than the $10 million per issuer.

I would like to note for the record that on page 3 of my testimony there is a typographical error in that the dollar amount in line 3 of the next to last paragraph should read $5 million and not $10 million.

In closing, I would like to say that we need your help to correct the current situation by providing a low cost financing option for small health care institutions in New York and around the country. We recognize that there are other issues such as the limitation on advance refundings that could also contribute to reduction in the cost of health care provided throughout the country.

We welcome the opportunity to address this and other related issues at a future date. Thank you for the opportunity to appear before you today.

Mr. MCNULTY. Thank you very much.

[The prepared statement follows:]

STATEMENT OF JOHN G. MARTINEZ, EXECUTIVE DIRECTOR, NEW YORK STATE MEDICAL CARE FACILITIES FINANCE AGENCY

Mr. Chairman, Members of the Committee, my name is John Martinez and I am Executive Director of the New York State Medical Care Facilities Finance Agency (MCFFA). I want to thank you for the opportunity to appear before you today to discuss how current tax law impacts on our ability to help reduce the cost of providing capital for health care provides in the inner city through the tax-exempt financing.

As you know, New York State has the oldest health care system in the country. Additionally, New York has a major concentration of health care clients in the New York City metropolitan area. The combined need for modernization, expansion and continued refinement of the system coupled with the dramatic demand for appropriate, affordable, quality health care that has led to an increased need for capital market access.

MCFFA is a public benefit corporation created by the New York State Legislature to provide capital financing for hopsital and health care providers throughout New York State. In this capacity, we have issued in excess of $9 billion dollars in tax-exempt bonds, with an expectation that we will issue in excess of $2 billion in the next 18 months. However, despite this significant volume we do not find it possible to provide capital access for some of the most important and neediest borrowers - the primary care health providers. This is the front line of health care delivery in our urban centers; you may know the entities as community health centers. I am here today to seek your support for a change in the bank deductibility rule by adoption of activities which we believe will: (1) provide a better point of access to the capital markets for small institutions needing assistance; (2) help borrowers to reduce expenses and the risk of bond defaults; and (3) help reduce the level of revenue loss for the US Government resulting from an inability to generate a significant reduction in the cost of health care delivery. I am here to offer strategies which can immediately serve to reduce the health care costs in two respects: reduction in defaults of non-rated bonds and lower the interest rate on proceeds raised through the issuance of tax-exempt bonds.

Health Care Borrowers and the Tax Exempt Bond Market

As you know, the IRS code presently gives 501(c)(3) health care institutions access to the capital markets on a federal tax-exempt basis. This access substantially reduces costs of borrowing, which are eventually included in health care charges that are passed along to consumers and the health care reimbursement system. For borrowers, tax-exempt financing generally represents the lowest cost of capital. Thus, for smaller and financially weaker institutions, access to tax-exempt financing can often be the determinative factor in making a project financially feasible.

501(c)(3) institutions do not have direct access to the tax-exempt markets, but engage a governmental bond issuer like MCFFA to act as a conduit on their behalf in the borrowing process. Unfortunately, current tax law restrictions on bank deductibility limit the ability of larger conduit issuers like MCFFA to provide the most cost-effective financing for the many small 501(c)(3) borrowers who come to us with smaller projects.

The Role of Banks In The Small Tax Exempt Market

Private placements with bank lenders represent often the only affordable financing option for small tax-exempt issues because the issuance costs associated with a public tax-exempt issue in an amount less than $5 million are generally too costly to be affordable to small health care borrowers. For these smaller issues, private placement of the debt with banks affords substantial cost savings. While a health care institution should never limit its search for capital to just bank financing, a thorough review of all options may indicate that this is the best or possibly only financing option available. Thus, access to this bank lender market can often mean the difference between a timely, successful project, and having to delay delivery of necessary services.

Non-Rated Bond Defaults

In a 1993 report prepared by the Kenny S&P Evaluations Services and Kenny S&P Information Services it was noted that from January 1, 1980 to December 31, 1991, there were 98 rated and 628 non-rated municipal bond defaults totaling approximately $8.63 billion in defaulted principal amount. Approximately 76% of all non-rated defaults by dollar volume were on health care bonds (e.g. hospitals, retirement facilities, nursing

homes) and industrial development bonds (e.g. hotels, factors, office buildings). However, health care bonds alone comprised approximately 46% of the total dollar volume of non-rated defaults. Further, almost 90% of all the non-rated defaults occurred on issues that were less than $10 million in size. Finally, non-rated bonds issued to finance health care projects went into default at a rate that was amongst the fastest of all non-rated defaults (43.75 months).

We believe that this appalling series of facts is reflective of a systemic problem which exists because of current tax law. Specifically, most of the health care financings in a principal amount of less than $10 million are financed as a "one shot" activity rather than as part of a formally structured, closely regulated programmatic approach. This is true because of the inability of large statewide issuers like MCFFA to provide cost-effective access to capital markets for small borrowers.

Current tax laws regarding bank eligibility for small bond issues preclude many of New York's smaller health care institutions from placing tax- exempt bonds with bank lenders because current law restricts such placements to small issuers -- those which issue less than $10 million of bonds per year. This inability to use banks to purchase the tax exempt obligations of small borrowers forces these borrowers to pay higher borrowing costs which, in turn, contributes to a higher rate of defaults for such facilities. We appreciate the inclusion of a provision in last year's H.R. 11 to raise the current limit on bank deductibility from $10 million to $25 million per issuer. This change, however does not adequately address the problem faced by issuers seeking to issue small tax-exempt obligations to benefit small borrowers because it still places limitations on such placements by issuer, rather than by borrower. This restriction limits state-wide issuers like MCFFA from making low-cost tax-exempt financing available to the many small health care institutions that could benefit from new borrowing. We are therefore seeking your support for an alternative proposal -- namely to change the current bank eligibility exemption from $10 million per issuer to $5 million per borrower. We believe this change would (1) allow the Agency to better provide financing for small institutions needing assistance, (2) help borrowers to reduce expenses and the risk of bond defaults; and (3) possibly lose less revenue for the Government than the proposal embodied in HR 11.

The Problem with Present Tax Laws Governing Bank Deductibility

Bank lenders are usually only interested in purchasing tax-exempt bonds which, under the new 1986 tax act, are deemed to be "bank eligible" (i.e., bonds for which the carrying costs are deductible). Eligibility is based upon whether the issuer reasonably expects to issue less than $10 million in tax exempt bonds in that year. If the answer is yes, then "small issuers" can issue "bank eligible" bonds. Unfortunately, each year state-wide issuers like MCFFA will always issue more than the allowed limit of $10 million (or $25 million in HR 11) because the state-wide issuers issue obligations for many borrowers, large and small within the state. (Last year alone, for example, MCFFA issued over one-billion dollars in health-care bonds.) Therefore, a hospital in New York that needs to borrow less than $5 million must either pay the increased costs of a public issuance (where that is even possible) or else use a small local issuer that will issue less than $10 million in that year (assuming such an issuer is even available.) The latter option prevents borrowers from taking advantage of the significant benefits of using a state-wide issuer.

State issuers like MCFFA possess the expertise needed to evaluate the availability of potential projects and design tax-exempt offerings which meet industry standards for safety and soundness. They have a staff of qualified finance experts who can assist in selecting the appropriate financing option, negotiate covenants and confirm pricing for each financing. They can also standardize the financing process with a high level of

quality, making sure that small borrowers and projects receive good representation. State issuers can also do one financing for all projects a borrower may have within the state, thereby reducing financing costs. These issuers are also knowledgeable about new financing techniques which they in turn offer their constituent borrowers, and remain involved with projects when problems develop after a financing is completed.

Many local issuers lack such expertise, with potentially harmful consequences for the borrower and the investing public. In the case of health care bonds, 95% of defaulted loans -- by both number of issues and dollars issued -- have been issued by local, rather than state-wide issuers. Moreover, in urban areas like New York City a qualified local issuer does not exist because the locality itself is likely to issue over the $10 million limit.

In the setting of a city, county or other governmental entity borrowing on its own behalf for its own capital projects, (e.g. roads, sewer, or water projects) the current bank deductibility policy which gives special treatment to small issuers may make good sense. For small borrowers, tax-exempt bank lending should be maintained in order to insure and enhance their access to capital. When it comes to 501(c)(3) conduit borrowings, however, MCFFA believes that the same principles should be applied.

If a 501(c)(3) health care institution reasonably expects to issue less than the requisite dollar amount of tax-exempt bonds in the year of issuance, then its bonds should also be bank eligible regardless of the conduit issuers' activity on behalf of other unrelated borrowers in that same year. To penalize small health care institutions for using a large conduit issuer (which in New York is the only one available) these borrowers are deprived of using the best or only plan of finance available -- direct bank lending.

The following subgroups of New York 501(c)(3) borrowers are particularly affected by this problem:

1. Health care institutions in larger urban areas where other capital needs by the city or special local authorities exceed the threshold for bank eligibility.
2. Health care institutions in smaller communities where the bonds could be bank eligible but where the city wishes to keep the capacity for its future capital needs.
3. Health care institutions wishing to use MCFFA as a conduit issuer for a bank eligible financing, but are precluded from doing so because of the volume of MCFFA's annual debt issuance.

New York plans to undertake a major initiative to approve community health center throughout the State. Direct placement with bonds would be a very helpful tool to accomplish this.

The Solution

As it relates to conduit financings on behalf of 501(c)(3) borrowers, bank eligibility of tax- exempt bonds should only require a small borrower test -- not a small issuer test. The limitation in this case should be $10 million because issues over that amount can in most instances be feasibly and economically accomplished with a public sale rather than a private placement. This change will greatly improve the access to capital for smaller health care institutions with small capital projects by making tax-exempt financing available to all on an equal basis. More timely financings (often at a lower cost) will be completed, balance sheets will be improved and long-term creditworthiness of these institutions will improve. If Congress wants to assist small 501(c)(3) borrowers, this is an ideal clarification to be made.

We believe this material describes the problems and inequities that current law has created regarding bank eligibility to purchase bonds issued for small health care institutions in New York. We all need your help to correct the current situation by providing a low-cost financing option for small health care institutions in New York. We recognize that there are other issues, such as the limitation on advance refundings, that could also contribute to a reduction in the cost of health throughout the country. We welcome the opportunity to address this and other related issues at a future date. Thank you for the opportunity to appear before you today.

Mr. MCNULTY. Next we will hear from Larry Gage, who is the president of the National Association of Public Hospitals.

STATEMENT OF LARRY S. GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Mr. GAGE. Thank you very much, Mr. Chairman. The National Association of Public Hospitals has as members over 100 urban public and private safety net hospitals and health systems which we believe comprise America's most important urban health and hospital system. I am pleased to submit my prepared testimony for the record and summarize it very briefly in my oral presentation.

Mr. MCNULTY. Yes, without objection, the testimony of all of the witnesses will be made a part of the permanent record.

Mr. GAGE. NAPH members, with an aggregate budget of over $14 billion, provide nearly two-thirds of their services to Medicaid patients and the uninsured poor. This safety net is increasingly threatened today by a number of factors affecting our Nation's inner cities. These factors are graphically illustrated by some dramatic new statistics developed by the National Public Health and Hospital Institute under a grant from the Robert Wood Johnson Foundation, and let me briefly summarize.

With respect to violent crime, the rate of aggravated assault rose nearly 71 percent between 1980 and 1990 in the 100 largest metropolitan areas, while total violent crimes increased over 31 percent. Regionally the greatest increases were in the North Central part of the country, with 128 percent increase, and in the South, which increased 71 percent. Births to teenage girls under 15 increased 23.4 percent between 1980 and 1990 in the 100 largest cities with the greatest increases in the West and Northeast.

With respect to changes in the incidence of disease between 1985 and 1990, AIDS posted the greatest increase, or 211 percent in the 50 largest cities, followed by syphilis, with 81 percent, and tuberculosis, with 30 percent. In the case of syphilis and TB, these dramatic increases in the last half of the decade came after a long period of decline. The incidence of other preventable diseases also began to increase between 1985 and 1990 after prior declines, including such childhood diseases as measles, mumps, and chicken pox.

With respect to urban hospital utilization in the 100 largest cities in the 1980s, the use of inner city hospital emergency rooms and outpatient departments increased by over 39 percent, to nearly 100 million visits in 1990. Urban public hospitals in the Northeast experienced the highest volume of outpatient and emergency hospital care, with an average of 413,000 visits per year in 1990. The New York City Health and Hospitals Corporation reports that 9 low-income communities in the Bronx, Manhattan, and Brooklyn had only 28 primary care physicians in private practice serving a total population of over 1.7 million.

As a result of these and other factors and trends described in my prepared testimony, many of the public health and community-wide services provided by safety net hospitals are in danger of deterioration. Trauma centers, high risk obstetric units, emergency psychiatric units, drug abuse treatment programs, burn centers, neonatal intensive care units, all are overflowing at a time when

State and local budget crises often require reductions, not increases in funding.

In your letter of invitation you asked for our opinion of a number of specific tax proposals, and for suggestions about additional tax related provisions that might improve inner city health and safety conditions. In particular, you asked for comments on a new excise tax on guns and the dedication of revenues raised by that tax to a new trust fund. While we would also support sweeping gun control measures in addition to a new tax, NAPH would strongly support such a concept.

Since current third-party reimbursement is simply inadequate to support 24-hour, standby trauma services required in many urban areas, we believe it is unlikely that health reform will fill that gap. We further urge you to broaden both the trust fund and the taxes that might support it to include support for services required by other kinds of violence and trauma. For example, additional taxes on alcoholic beverages which are often a contributing factor in inner city violence might also be dedicated to the fund. Other suggestions are in my prepared testimony.

In conclusion, as important as it is to treat the victims of inner city violence and trauma, such treatment alone will never solve the underlying social as well as health problems that have led to the need for these services. While these problems are far broader than health care, I have suggested in my prepared testimony several additional ways in which the Tax Code may be used to assist inner city health care providers and patients. These include tax credits and incentives for additional medical professionals facilities and particularly for those that provide primary and preventive care that can relieve overcrowded hospital emergency rooms and trauma centers and identify medical problems before they become traumatic. I am happy to answer any questions.

Mr. HOAGLAND [presiding]. Thank you, Mr. Gage.

[The prepared statement follows:]

Statement of Larry S. Gage
President, National Association of Public Hospitals

before the

Subcommittee on Select Revenue Measures
Committee on Ways and Means
U.S. House of Representatives
Washington D.C.
June 29, 1993

I am Larry Gage, President of the National Association of Public Hospitals (NAPH), whose members include over 100 of America's metropolitan area safety net hospitals. I am pleased to have this opportunity to testify this morning on health and safety issues affecting inner city and other distressed communities. Your attention to this topic is both timely and urgent. In addition to the future debate on health reform, many of the tax and spending provisions of the current budget reconciliation legislation that will be in conference next month will have a profound impact on our nation's fragile inner city health safety net.

I would like to accomplish four things in my testimony this morning:

- First, I would like to bring you up to date with a few key facts about the situation of America's urban safety net hospitals and the patients they serve, including some dramatic new facts, from a Robert Wood Johnson Foundation supported study, that are being released today for the first time.

- Second, I would like to comment specifically on the tax proposals set out in your letter of invitation, strongly endorsing your proposal for a new trust fund to be established with an excise tax on guns and suggesting a number of other tax measures that are likely to benefit our nation's urban health safety net and its patients.

- Third, I will set out a number of NAPH's recommendations and concerns with respect to national health reform, to assist you in preparing to consider the recommendations that will soon be forthcoming from President Clinton (as well as any other plans that may be on the table).

- Fourth, and finally, I would like to call your attention to several more immediate needs, including our concerns about Medicaid disproportionate share hospital payments and certain other provisions in the pending reconciliation conference and the serious capital infrastructure needs facing our urban health safety net.

THE SITUATION OF AMERICA'S URBAN HEALTH SAFETY NET

Mr. Chairman, NAPH's 100 member institutions (taken together) comprise America's most important health and hospital system. With combined revenues of over $14 billion, these hospitals provide over 65% of their services to Medicaid and low income uninsured and underinsured patients. In other words, these hospitals already serve as "national health insurance" by default in most of our nation's urban areas. Your attention in this hearing to the urgent needs of America's urban health safety net has never been more welcome or necessary. This safety net is increasingly threatened today by a combination of factors.

Let me illustrate the urgency of this situation with a few simple facts about urban public hospitals and the patients they serve. Included among these points are a number of facts, drawn preliminarily from an ongoing study by the National Public Health and Hospital Institute, which are being announced today for the first time. The purpose of this study, which is being conducted by NPHHI with the support of the Robert Wood Johnson Foundation, is to gather a wide range of comparative data on the situation of public hospitals and their patients in our

nation's 100 largest cities. Information has been gathered for 1980 and 1990 (and in some cases for intervening years) using databases maintained by AHA, Medicare, the Census Bureau, Centers for Disease Control and the FBI, among others. The results are still preliminary and will not be formally released until later this year. Nevertheless, because of the urgency of your current inquiry, and your need to prepare for a budget conference with the Senate next month that will involve several important urban health issues, let me share with you some of the Institute's preliminary findings, together with other information developed by NAPH and others.

- **With respect to violent crime**, the rate of aggravated assault rose nearly 71% in the 100 largest MSAs, while total violent crimes increased 31.1%. The increase in the rate of aggravated assault was greater in the 25 largest cities, where it rose nearly 84% in the 1980s. Regionally, the greatest increases were in the North Central (128%) and South (71%).

- **The murder rate in the 25 largest cities also increased during the decade**, by nearly 11%. The largest increases in murder rates were registered in the West (52%) and Northeast (27%).

- **Births to teenage girls under 15 increased 23.4% between 1980 and 1990** in the 100 largest 100 cities, with the greatest increases in the West (52.2%) and Northeast (27.1%).

- **With respect to changes in the incidence of disease** between 1985 and 1990, AIDS posted the greatest increase (211%) in the 50 largest cities, followed by syphilis (81%) and tuberculosis (30%). In the case of syphilis and TB, these dramatic increases in the last half of the decade came after a long period of decline in their incidence. Other preventable diseases also began to increase between 1985 and 1990 after prior declines, including such childhood disease as measles, mumps and chicken pox. One recent measles outbreak in Milwaukee required the hospitalization of 266 children, mostly from low income families. **Over two thirds of these unvaccinated children were enrolled in Medicaid managed care plans at the time.**

- With respect to urban hospital utilization in the largest 100 cities in the 1980s, **the use of inner city hospital emergency rooms and outpatient departments increased by over 39%, to nearly 100 million visits in 1990.** Urban public hospitals represent just 7.4% of all hospitals but provided 18% of outpatient care and 19% of emergency care during this period.

- **Urban public hospitals in the northeast experienced the highest volume of outpatient and emergency hospital care**, with an average of 413,000 visits per year in 1990. Much of this staggering volume of hospital emergency care could be more appropriately and inexpensively provided in other settings, if such settings were available. The New York City Health and Hospitals Corporation reports, however, that nine low income communities in the Bronx, Manhattan and Brooklyn had only 28 primary care physicians in private practice, serving a total population of over 1.7 million inner city residents. For this reason, many urban public hospital systems are now moving aggressively to develop integrated systems of primary care and to decentralize such services, including Denver, Chicago, Houston and New York City.

- **Half of all urban public hospitals have trauma centers, and many offer the only available trauma care in their city or region.** Cook County Hospital, for example, provided 40% of all the trauma care in Chicago in 1990, with 95% of their inpatients admitted from the emergency room or trauma center.

- Between 1980 and 1990, low income patients were increasingly concentrated in just a small handful of inner city safety net hospitals. **Public general hospitals saw an increased Medicaid utilization during this period of 43.5% and the increase in public university hospitals was over 39%**, compared (e.g.) with reduced Medicaid utilization in private university hospitals of nearly 14%. The proportion of self pay patients also increased nearly 17% in urban public hospitals between 1980 and 1990, as compared with decreases of 16-41% in all other categories of hospital.

- **The numbers of uninsured have dramatically increased in recent years.** Despite all our rhetoric about reform, the number of completely uninsured Americans grew from 34 million uninsured in 1988 to 37 million last year. It is also now estimated that another 60 million are insured only part of the year, or have health insurance that will prove inadequate in the event of a serious illness. This is not just a temporary trend brought on by the recession: it has been exacerbated by disturbing trends among employers and insurers to reduce or eliminate coverage for many among the insured, including dependents, retirees, and individuals with AIDS and other serious medical problems.

- **Safety net hospitals are bursting at the seams.** Such hospitals today are providing an extraordinary volume of inpatient and outpatient care. 72 NAPH member hospitals across the nation averaged 260,000 emergency room and outpatient visits and 18,000 admissions in 1990 -- or over ten times the volume of the average American hospital. NAPH member hospitals totalled 18.7 million emergency and outpatient visits in 1990. NAPH members averaged an 82% occupancy rate in 1990, also far higher than other hospitals, with many safety net hospitals approaching 100%.

- **Safety net hospitals are both hospital and family doctor for the uninsured.** In 1990, 33% of all discharges and 30% of all inpatient days were not sponsored -- even by Medicaid -- in NAPH member hospitals; 48% of all outpatient and emergency room visits were also uninsured.

- **Safety net hospitals are uniquely reliant on governmental funding sources.** Just 17% of the gross revenues of safety net hospitals were derived from private insurance and 18% from Medicare in 1990, while 67% were attributable to Medicaid and "self pay" patients. Medicaid charges for NAPH members averaged $73 million and charges for "self pay" patients averaged $69 million in 1990. Typically, "self pay" is a euphemism for "no pay", and the only sources of payment for these patients are direct local subsidies and Medicare and Medicaid "disproportionate share hospital" ("DSH") adjustments.

- **Emergency and clinic patients are waiting longer to see doctors or be admitted.** 58% of NAPH hospitals reported periodic waits by emergency department patients of 12 hours or more for admission, and half of all hospitals surveyed reported that some patients were forced to wait more than 24 hours.

- **The many community-wide services provided by safety net hospitals are in danger of deterioration as well.** Trauma centers, high risk obstetric units, emergency psychiatric units, emergency drug abuse treatment programs, burn centers, neonatal intensive care units -- all are overflowing, at a time when state and local budget crises often require reductions, not increases, in funding.

In short, while we continue to delay the debate over expanding health coverage, the nation's Safety Net hospitals are providing care for uninsured patients **now**, and they are providing it to more and sicker people than at any other time in our nation's history.

NAPH COMMENTS ON PROPOSED TAX PROVISIONS

In your letter of invitation and announcement of this hearing, you have asked for our opinion of a number of specific tax proposals, and for suggestions about additional tax-related provisions that might assist the improvement of inner city health and safety conditions.

In particular, you have proposed a significant new excise tax on guns and the dedication of half of the additional revenues raised by that tax to a new Hospital Gunshot Cost Containment Trust Fund. While we would also support sweeping gun control measures in addition to a new tax, NAPH would strongly support such a concept, since current third party reimbursement is simply inadequate to support the kinds of 24 hour standby emergency and trauma services that urban areas require. We also believe it is highly unlikely that such services will be adequately funded by the rates likely to be set under any form of "managed competition" and that outside support will therefore continue to be needed even following the implementation of health reform.

We would further urge you to broaden both the trust fund and the taxes that might support it, to include support for services required by other kinds of violence and trauma that are prevalent in distressed neighborhoods. For example, additional taxes on alcoholic beverages -- which are so often a contributing factor in inner city violence -- might also be dedicated to the fund. Excise taxes on such commodities as motorcycles and on the excess horsepower of high-performance cars might also be added to the trust fund.

As important as it is to treat the victims of inner city violence and trauma, such treatment alone will never solve the underlying problems that have led to the need for these services. While these problems are far broader than health care, we would like to suggest several additional ways in which the tax code may be used to assist inner city health providers and patients.

The most pressing needs in many inner cities are for additional medical professionals and facilities -- and particularly for facilities and personnel that can provide primary and preventive care that can relieve overcrowded hospital emergency rooms and identify medical problems before they become traumatic. In that regard, let me briefly suggest a few ways in which the tax code can be used to help meet these needs:

- Tax credits, and perhaps preferential tax treatment of the expenses of starting up or expanding a practice group, can be provided to primary care physicians who are willing to locate in medically underserved neighborhoods.

- Tax credits could be provided to developers, similar to the low income housing tax credit, to develop outpatient and primary care facilities in underserved areas.

- The low income housing tax credit itself can also be made available to developers willing to help meet an important need by developing safe, secure housing for lower income hospital employees in inner city neighborhoods in proximity to essential health facilities (at present such credits cannot be used, under IRS regulations, for housing that is dedicated to a specific population.)

NAPH COMMENTS ON HEALTH CARE REFORM

Our failure to provide universal health coverage and access to care has for years been the single most glaring deficiency of our nation's health system -- one we share only with South Africa among Western nations. In the past two decades alone, there have been over a dozen major national health insurance initiatives, offered by the most important political leaders of our era, as well as scores of more modest proposals. Unfortunately, each of these proposals has generated influential opposition as well, virtually paralyzing all efforts to achieve needed reform. As a result, we have advanced very little in this arena since the enactment of Medicare and Medicaid.

Our nation's lack of universal health coverage is forcing safety net hospitals to treat an ever-broader population of Americans who have no access to other providers because they have lost their jobs, their insurance, or both. Rarely are these individuals able to become eligible for Medicaid -- yet rarely can they afford the cost of a serious illness either.

Being a relatively small organization, NAPH did not choose in the past to adopt a single, comprehensive proposal of our own, but rather to outline the characteristics we would like to see in any national health plan that is adopted by the Congress, or by a state. More recently, with the dramatic improvement in the prospects for health reform, NAPH has chosen to expand on those general principles -- to offer more specific and detailed suggestions in a number of areas, based on our intimate knowledge of the health status, and the broad range of both health and social needs, of America's urban uninsured.

Based on what we have learned about the general thrust of the plan under development by the Clinton Administration -- and the excellent work of Chairman Stark and the members of this Committee in recent years -- we would like to make the following observations and recommendations at this time:

1. ELIGIBILITY

A. The goal of national health reform must be nothing less than **universal and mandatory coverage for all residents.** While universality is generally acknowledged as a worthy goal, there appears to be debate over whether coverage should be voluntary or mandatory for employers, employees and the uninsured. The experience of NAPH members in many states makes clear that voluntary coverage will simply fail to reach many among the uninsured -- including many of the most vulnerable individuals and families. It is well accepted that in many states, the Medicaid program (which is voluntary) enrolls less than half of all potentially eligible patients. Only by requiring all individuals to be covered can a new system lead to genuine reforms. At the same time, care will need to be taken that such a requirement will not carry with it and unrealistic burden of co-payments and deductibles for low income patients. Even those with incomes of up to 200% of poverty will have an extremely hard time meeting such co-payments -- which means that they will become bad debts, requiring new forms of cost shifting, for the providers that serve them.

B. It will clearly be necessary -- if only for budgetary reasons -- for universal health coverage to be phased in. In that case, it is important that **the most vulnerable populations among the uninsured should be covered first** -- including the chronically or seriously ill, as well as women and young children not otherwise eligible for Medicaid. Among the employed uninsured, particular attention will need to be paid to dependents, part time employees, and seasonal and migrant employees, to prevent these populations from falling through the gaps.

C. We are concerned about reports that current Medicaid patients may remain outside the system that will be proposed by the Clinton Administration -- with inadequate payment rates locked in at current levels and no obligation on the part of new affordable health plans to enroll them. Such a "ghettoization" of Medicaid patients will perpetuate (and make worse) the discrimination that already occurs against Medicaid patients. Inadequate payments will further starve those safety net plans and providers who will remain willing to serve them.

D. It is also essential to recognize that, however noble the goal of universality, **there will always be coverage gaps** and individuals who fall through them. An institutional safety net, including hospitals, community health centers, and other providers, will need to remain in place (and be publicly financed) to serve these patients. Even Hawaii's much-touted health plan has gaps -- as is evidenced by the continued existence of a state-subsidized public hospital system.

E. It is imperative that (unlike Medicaid, AFDC and food stamps today) **the eligibility process should be kept as simple as possible.** In many cases, as our experience with Medicaid demonstrates, individuals who may otherwise be eligible -- especially in inner cities and isolated rural areas -- will simply not sign up for a new national health plan, even if mandatory. Rather, they will present themselves to providers in the future as they do today -- sick or injured, addicted or mentally ill, homeless, often unable to provide us with basic information about themselves. As eligibility is phased in for various groups, providers must be able to rely on the presumptive eligibility of any individual who shows up in the emergency room.

F. It is important to understand that simply giving a patient a card will not ensure that his or her needs will be met. A dramatic recent indication of that fact occurred last year in Milwaukee, when well over 200 children were hospitalized (and several died) as a result of a measles epidemic that could have been prevented through simple immunizations. **Over two thirds of the children hospitalized were enrolled in Medicaid managed care plans!**

2. BENEFIT PACKAGE

A. A basic benefit package and "basic risk pool" should be developed, based on the mandatory federal Medicaid benefit package, but with **a greater emphasis on (and first dollar coverage for) primary and preventive care.** For cost containment purposes

and so that it may be applicable to the widest possible population, the basic package should include catastrophic limits (in effect, a "stop loss") on hospitalization and high tech providers and treatments.

B. As with eligibility, any system of health reform must acknowledge that there will be a number of services whose costs will continue (in whole or in part) to fall outside either benefit package. These services will range from costly 24-hour standby services such as trauma, burn care, and neonatal intensive care, to traditional public health and even non-health social services that are often needed by low income patients whether or not they have coverage. These **safety net and community-wide services must continue to be provided and funded outside the health insurance system**, through add-on community service payment adjustments or through direct grants or subsidies.

3. FINANCING HEALTH REFORM

A. NAPH strongly supports **a broad array of financing mechanisms for universal health coverage**, including taxes on excess employee health coverage, so-called "sin taxes" on alcohol and tobacco, sliding scale cost sharing for higher income insured individuals, and increased Medicare cost sharing.

B. NAPH agrees that **cost containment must be an essential element** of any national health plan, and would support cost containment methodologies that are applied equitably across all insurers and providers (rather then being limited only to public programs). To be effective, cost containment strategies must be administered locally, at the community level, and should not penalize efficient providers (but rather, should target underutilized or otherwise inefficient providers).

C. In recent years, the so-called "disproportionate share hospital" ("DSH") adjustments paid by Medicare and many Medicaid programs have been of particular importance in helping safety net hospitals make ends meet, assisting overburdened local governments in preserving and improving health safety net services. There has been some talk of using these adjustments as a "funding source" for national health reform. However, we believe it is essential that these adjustments be continued and strengthened until such time as other sources of funding are available AND FULLY PHASED IN for the presently uninsured.

D. We further believe that many residual community-wide public health and social services will continue to be needed even after most uninsured Americans have been provided some form of health coverage. Such services will range from emergency "standby" services such as trauma centers, burn centers, neonatal intensive care, and the like, to public health and social services that will still be needed by low income patients. For this reason, as part of health reform, NAPH is proposing the identification of "essential community providers" ("ECPs") -- both clinics and hospitals -- that will continue to provide access and essential services to inner cities and other underserved areas even under a new national health plan. We are concerned with reports that, while the Clinton Health Task Force may recommend adoption of such an ECP definition, it may not include urban public hospitals within such a definition. Failure to include hospitals as well as clinics and other providers would betray a gross ignorance of the limited access of many millions of inner city residents to adequate health care today -- and of the fragile and under funded health system that serves them. We believe that the definition of ECP in important health infrastructure capital financing legislation reintroduced only last week by Health Subcommittee Chairman Pete Stark should be incorporated into any health reform legislation.

4. PLAN ADMINISTRATION

A. NAPH believes that the concept of "managed competition" should be given an opportunity to work wherever it may prove to be feasible. However, based on our extensive experience serving the urban uninsured, we are concerned that managed competition as described in the literature to date may be less effective in some areas, including inner cities and isolated rural areas. This is true for several reasons, including

the dearth of a sufficient number and variety of providers to guarantee access and choice in those areas; the checkered history of efforts to introduce competitive models (such as the California PHP scandals of the early 1970s and the Florida scandals of the 1980s); and the nature of the patient population itself in such areas.

B. It must be further recognized in implementing "managed competition" that the playing field is not currently level for either providers or patients -- especially in the inner cities and remote rural areas. To be equitable, and to guarantee access for patients in such areas to the broadest range of health and social services, a plan must ensure that all safety net providers (including health centers as well as public hospitals) are given an equal opportunity to develop and participate in competitive plans.

C. If managed competition is adopted, with "HIPCs" or "health alliances" serving as brokers for the poor, there must be significant safeguards against abuses by insurers and others who may develop plans to be offered under this system. Of particular concern is the possibility of adverse selection and "targeted marketing" by some plans -- cream-skimming, if you will -- that will leave the sickest and the poorest to enroll in "public plans". NAPH will be developing a detailed list of possible safeguards, including mandatory open enrollment, limitations on advertising, and mandatory random assignment of "high risk" patients.

D. NAPH supports the broadest possible range of insurance industry reforms, including full portability, a ban on preexisting conditions, and community rating for all plans and all employers.

MEETING THE MORE IMMEDIATE NEEDS OF URBAN SAFETY NET HOSPITALS

Many supporters of various national health reform proposals have suggested that, if reforms were enacted, there would no longer be a need for an institutional health safety net. We can only note that the same thing was said about the enactment of Medicare and Medicaid. Given the strong likelihood that future changes will continue to be incremental and piecemeal, NAPH believes that there will continue to be a strong need for the public health safety net in our nation's metropolitan areas. For many reasons, even if national health insurance were adopted this year, America's safety net institutions will need continued support well into the future:

- Any new health reform system is likely to be phased in over a long period of time.

- Even with coverage, many of our current uninsured will be little better off than Medicaid patients, who today find their access restricted in many states to those "open door" hospitals and clinics who will serve them.

- It is also important to recognize that many of the current uninsured also suffer from a variety of health and social problems very different from those of middle America -- AIDS, drug abuse, tuberculosis, and teenage pregnancies are often augmented by homelessness, joblessness, and lack of education; while no health care provider can fully cope with all of these problems, our urban safety net hospitals are the only ones even trying to do so today.

- In addition, we must recognize that even for insured individuals today, with the dramatic cost containment efforts already being imposed by both public and private payers, many expensive and unprofitable "standby" services (such as trauma, burn care, and neonatal intensive care) are also far more likely to be available in safety net hospitals.

- Finally, many safety net hospitals are simply located in the geographic areas where most of our uninsured Americans reside -- areas which, even if national health coverage were fully implemented, most other health care providers will continue to be unwilling or unable to serve.

Inner city safety net providers are usually the first -- and in many cases the only -- responders to many significant urban health crises. The Los Angeles County health and hospital system generally, and the Martin Luther King/Drew Medical Center in particular, treated the vast

majority of victims of the South Central Los Angeles disturbances last year. Three public hospital systems in South Florida provided the vast majority of health services in the days and weeks following Hurricane Andrew last fall. The Emergency Medical Services division of the New York City Health and Hospitals Corporation was commended for extraordinary heroism and responsiveness following the World Trade Center disaster earlier this year. As recently as last month, in the wake of harrowing reports of a new and mysterious epidemic on the Navaho Indian Reservation, it was the University of New Mexico/Bernalillo County Medical Center, the Indian Health Service, and the Centers for Disease Control that were on the frontlines providing extraordinary care and fearlessly leading the search for the possible sources of the epidemic. Time after time, it is our urban safety net institutions that take the lead in public health crises and emergencies -- in the fights against AIDS, substance abuse, gang violence, drug resistance tuberculosis, high risk pregnancy -- the list goes on and on.

Can we really afford to imperil this safety net today -- even in the name of deficit reduction and health reform? I think not. We must thus be extremely careful about dislodging any current funding mechanisms for public health systems in general, and safety net hospitals in particular, unless we are certain that we have workable and fully implemented NEW systems and funding sources to take their place. Moreover, we must continue to press forward with more targeted programs and reforms that support "stand by" health and social services and safety net providers.

For these reasons, I would like in particular to call your attention to the Medicaid disproportionate care hospital (DSH) payment provisions -- and to the proposed reductions in Medicare and Medicaid spending generally -- that are in the House and Senate versions of the reconciliation bill. While I recognize that Medicaid is not within your Committee's jurisdiction, you have indicated a willingness to pay attention to a broader range of health issues affecting inner city providers and patients. With respect to DSH, the House and Senate bills include provisions that would place a hospital-by-hospital cap on such payments. The Senate provision would be effective one year later than the House version. While this provision is aimed at states that have apparently abused the Medicaid program by applying DSH payments to non-health related services or activities, it also dramatically affects inner city hospitals in several cities and states that have not been involved in such abuses. Particularly affected would be inner city public hospitals in Los Angeles, Chicago, Seattle and New Orleans. We strongly urge you to support the Senate implementation delay of this provision, and to work with Energy and Commerce Chairman John Dingell and Subcommittee Chairman Henry Waxman in conference to craft a provision that addresses the legitimate concern about abuses without adversely impacting inner city health systems.

In addition, on the broader subject of Medicare and Medicaid spending reductions and entitlement caps, we would strongly urge you to reject the broader spending cuts in the Senate-passed bill, and in particular the proposed reduction in Medicare graduate medical education payments.

Finally, we would strongly urge your support and cosponsorship of legislation introduced last week by Health Subcommittee Chairman Pete Stark that would address the urgent capital infrastructure needs of inner city and remote rural providers that serve underserved neighborhoods. This is a revised version of the legislation endorsed last summer by Chairman Rangel at a press conference held in New York City at Harlem Hospital.

I would be pleased to answer any questions you might have at this time.

Mr. HOAGLAND. Mr. Greenspan.

STATEMENT OF BENN GREENSPAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, MOUNT SINAI HOSPITAL MEDICAL CENTER OF CHICAGO

Mr. GREENSPAN. Thank you, Mr. Chairman. I would like to thank you and the members of this committee for this opportunity to testify on the health care issues facing inner city communities. At Mount Sinai we consider ourselves to be one of those safety net hospitals mentioned in previous testimony. We are a private institution filling a public mission. For many years we have served as a laboratory for a number of innovative and successful approaches to the health problems of low-income communities. I am here today to talk about the importance of encouraging community-based prevention and public health programs and the importance of protecting the safety net institutions that create those programs.

I would like to begin by telling you something about Mount Sinai and the communities we serve. Mount Sinai is a 469-bed teaching hospital that provides primary, secondary and tertiary care on the west side of Chicago in one of the poorest communities of this country. Mount Sinai today is one of the major providers of care to low-income patients in the State of Illinois. Only 6 percent of our patients are covered by commercial insurance.

Close to 50 percent are covered by Medicaid. About 10 percent have no coverage whatsoever. The hospital provides millions of dollars of free care each year. Our mission is explicit. We are proud to accept all patients regardless of their ability to pay and regardless of their lack of insurance coverage. We turn nobody away.

We are a level 1 trauma center, the highest level certified in the State of Illinois. We are also a level 3 perinatal center, again the highest level certified in the State, providing care to high risk infants. We also funded and initiated 18 primary care sites, and are one of the largest providers of community health care programs in the country, 13 of those sites federally qualified.

Mount Sinai has received national recognition for our community-based programs, most recently as the recipient of the American Hospital Association's 1992 Foster McGaw award for hospital excellence and community service. These programs include school-based health education and pregnancy prevention, comprehensive primary medical care and school-based clinics, community-based mental health services, case management of high risk pregnancies, WIC nutrition services, adolescent pregnancy treatment and prevention programs, parenting education, a health and ministry program that joins our resources with those of various churches, tenant organizing, and last but not least community and housing redevelopment for the west side of Chicago.

I have included a more complete listing of these programs in my written testimony. Our west and south side neighborhoods are a microcosm of this Nation's urban social and health care problems. They reflect all the needs of the underserved throughout our society, urban and rural, and highlight the challenges of national health reform. The areas we serve are predominantly African-American and Latino with poverty rates ranging from 38 to 53 percent. While the rest of the country was experiencing an 8 deaths

per 1,000 infant mortality rate, the infant mortality rate in our community is over 20 deaths per 1,000 live births, in some areas getting higher than 24 deaths per 1,000.

Nearly one-third of the babies born in this community are born to adolescent mothers, and up to 85 percent of the births in many of our areas are to single mothers. As you all know, this is a veritable prescription for high risk. In fact, the rate of low birth weight infants in the area tends to be 50 percent higher than that for the State of Illinois as a whole, but maternal and infant health are not the only significant health problems of these underserved members of our society. Health status in general is very poor in these communities, death rates from heart disease, cerebrovascular disease and cancer are more than double those in the rest of the State.

Death rates due to homicide, cirrhosis, diabetes, hypertension, pneumonia, injuries, and firearms incidents are all extremely high in our communities. Of particular concern to us is the impact of violence on the lives of young men in our community. It is no secret that violence is the major public health problem for these young men. As a level 1 trauma center, we are acutely aware of this fact.

Most trauma centers primarily treat victims of motor vehicle accidents. At Mount Sinai we are far more likely to be treating victims of what the State of Illinois politely calls penetrating trauma, gunshot and knife wounds. We can tell you firsthand that it is not sufficient to fund and nuture the care of these victims. It is not acceptable to keep catching the broken bodies every day and putting them back together. The great financial and emotional cost, it is simply not acceptable to continue rescuing the tiniest babies, supporting their fragile and impossibly small bodies until they can breathe on their own, until they can be fed, not through tubes, and then send them home to continue the same gruesome cycle. We believe that it is not merely imperative, it is an absolute necessity for those of us who provide care in this country to find ways to prevent these health problems before they reach our hospitals.

In a real sense the patients who reach our trauma center and recover from those wounds, the infants who survive because of the care of our neonatal intensive care units do not represent our successes, but really our failures, ours and the failures of society, society that does not act to prevent bad birth outcomes or to adequately address the problems. I would like to tell you about just two programs that work and typify the kinds of approaches that we believe deserve encouragement and support. Unfortunately, these are often the very programs for which there is little or no support available.

The first programs are window of opportunity school health initiatives. Many of the children in our area become sexually active when they are just that, children. In addition, these children are at far higher risk for illness ranging from asthma to measles than their peers in other areas of the city. We responded to these problems with a comprehensive health education, health promotion counseling program designed for fourth through eighth graders, and that is for children as young as 8 to 9 years old. This program aimed not only at providing health information but also at developing self-esteem in these children. These are children who will have to confront a number of serious issues from sexual activity to gang

participation to street drugs in a few years, a few months or even a few weeks. We try to give them the building blocks to make those crucial decisions.

In one school where the program was offered for 3 years, pregnancy among these grade schoolchildren dropped from 15 pregnancies per year to none, 15 pregnancies in 1 year in 1 grade school. We were able to achieve this with one staff person. The cost of that staff person is minuscule compared with the cost of caring for the number of high risk births we could anticipate from these very young girls.

The second low cost but highly effective program addresses the serious and far-reaching problem of low birth weight babies. A few years ago the State of Illinois funded a case management program at Mount Sinai known as the problem pregnancy program. Through this program a case manager is assigned to women who have all been identified at high risk for adverse pregnancy outcomes, low birth weight, premature birth and other problems. The case manager's job is to ensure that women in this program receive appropriate medical services as well as other support services they may need throughout their pregnancy.

By aggressively involving these women in their care and making sure that they receive the services that they need, we create a program in which not 1 of 150 consecutive women participating delivered a single low birth weight baby. These are just two examples of programs that are common responses to serious health and social problems. Unfortunately, these are exactly the types of programs that do not receive significant support. They are not automatically built into public and private reimbursement. They certainly do not add to a hospital's profit margin. They certainly do not gain a hospital the professional distinction accumulated by sitting back and catching the problems with expensive high tech services.

Too often they are the programs offered only by institutions such as ours that have no way of applying financial resources to guarantee their continuance.

Mr. Chairman, those of us whose institutions deliver effective community-based care know that using our resources this way is effective and can make a difference, but our institutions are crumbling. While we shoulder this load, we have been underpaid chronically, we end up paying more for goods, more for labor, more for professional services. It is almost impossible for us to get debt worthy credit ratings. Our very walls are crumbling and one day we will be extinct. We look to our Members of Congress to have the wisdom to recognize the need to maintain these safety net hospitals and their programs in order to assure that national health reform does not fail to reach the very people it aims to cover.

You asked us specifically what we support, and we would like you to know that we as a private hospital with a public mission support the increased excise taxes on guns, alcohol, and tobacco. We support taxing other hospitals that don't provide charity care in our communities. We believe that there are necessary tax incentives that must be applied to recapitalize the infrastructure of the safety net hospitals.

I appreciate the opportunity you have given me to tell you about our community. The problems we have are those of many communities throughout the country. We believe that there are solutions to those problems and that they can be achieved with creativity, common sense, and commitment to the people of these communities. Thank you.

[The prepared statement and attachment follow:]

Testimony before the
Subcommittee on Select Revenue Measures
Committee on Ways and Means
Benn Greenspan
President/Chief Executive Officer
Mount Sinai Hospital Medical Center of Chicago

Good afternoon. I am Benn Greenspan, president of Mount Sinai Hospital Medical Center of Chicago. I would like to thank you, Chairman Rangel, and the members of the committee for the opportunity to testify today on the health care issues facing inner city communities. At Mount Sinai, we have served as a laboratory for a number of innovative and successful approaches to the health problems of low-income communities. I hope to demonstrate to you today the importance of encouraging community-based prevention and public health programs.

I would like to begin by telling you something about Mount Sinai and the communities we serve. Mount Sinai is a 469-bed teaching hospital that provides primary, secondary, and tertiary care on the West Side of Chicago in one of the poorest communities in this country. Mount Sinai today is one of the major providers of care to low-income patients in the state of Illinois. Only 6% of our patients are covered by commercial insurance. Close to 50% are covered by Medicaid. The hospital provides millions of dollars in free care each year. Our mission is explicit. We are proud that we can accept all patients regardless of their ability to pay or their lack of insurance coverage.

We are a Level I trauma center, the highest level certified in the state of Illinois. We are also a Level III Perinatal Center, again the highest level certified in our state, providing care to high-risk infants. We operate 18 primary-care sites, and are one of the largest providers of community health care programs in the country. Mount Sinai has received national recognition for our community-based programs, most recently as the recipient of the American Hospital Association's 1992 Foster McGaw award for hospital excellence in community service. These programs include school-based health education and pregnancy prevention, providing primary care in school-based clinics, community-based mental health services, case management of high-risk pregnancies, WIC nutrition services, adolescent pregnancy treatment and prevention, parenting education, a health and ministry program joining our resources with area churches, tenant organizing, and community and housing development. I have included a complete listing of these programs in my written testimony.

Our West and South Side neighborhoods are a microcosm of this nation's urban social and health care problems. These areas are predominantly African-American and Latino, with poverty rates ranging from 38% to 53%. While the rest of the country was experiencing "8 deaths per thousand" infant mortality rates, the infant mortality rate in our community is over 20 deaths per thousand live births, going higher than 24 per thousand births in one community area. Nearly one-third of the births in this community are to adolescent mothers--and up to 85% of the births in many of our communities are to single mothers. As you all know, this is a prescription for high risk. In fact, the rate of low-birthweight infants in the area tends to be 50% higher than that for the state as a whole.

Maternal and infant health are not the only significant health problems of the underserved members of our society. Health status, in general, is very poor in these communities. Death rates from heart disease, cerebrovascular disease and cancer are more than double those in the rest of the state. Deaths rates due to homicide, cirrhosis, diabetes, hypertension, pneumonia, injuries, and firearms incidents are all extremely high.

Of particular concern to us is the impact of violence on the lives of the young men in our community. It is no secret that violence is the major public health problem for these young men. As a Level I trauma center, we are acutely aware of this fact. Most trauma centers primarily treat victims of motor vehicle accidents. At Mount Sinai, we are far more likely to be treating victims of what the state of Illinois politely calls penetrating trauma -- gunshot wounds and knife wounds.

We can tell you, first hand, that it is not sufficient to nurture the victims. It is not acceptable to keep catching the broken bodies every day and putting them back together at great financial and emotional cost. It is simply not acceptable to continue rescuing the tiniest babies, supporting their fragile and impossibly small bodies until they can breathe on their own, until they can be fed - not through tubes - , and then sent home to continue the cycle. We believe that it is not merely imperative, it is necessary for those of us who provide health care in this country to find ways to prevent these health problems before they reach the hospital. In a real sense, the patients who reach our trauma center and recover from gunshot wounds ... the infants who survive because of the care in our neonatal intensive care unit do not represent our successes but our failures--our failures and the failures of a society that does not act to prevent bad birth outcomes or to adequately address the problems leading to traumatic injuries.

We do, however, cherish our successes in preventing some of these health problems. We know from our experience in community health programs that many of the problems we have seen in maternal and infant health, can be prevented -- at a relatively low cost. Unfortunately, these are often the very programs for which little support is available. I would like to describe just two programs that work and which typify the kinds of approaches we believe deserve encouragement and support.

The first program is our **Window of Opportunity School Health Initiative**. Many of the children in our area become sexually active when they are just that--children. In addition, these children are at far higher risk for illnesses ranging from asthma to measles than their peers in other areas of the city. We responded to these problems with a comprehensive health education, health promotion and counselling program designed for fourth through eighth-graders (that is, for children as young as 8 or 9 years old). This program aimed not only at providing health information, but also at developing self esteem in these children, and the ability to make good

decisions based on that enhanced expectation for their own future. These are children who will have to confront a number of serious issues -- from sexual activity to gang participation to street drugs -- in a few years, if not months. We try to give them the building blocks to make those crucial decisions. In one school where the program was offered for three years, pregnancies among these children dropped from 15 a year to none. Fifteen pregnancies in one year in one grade school! We were able to achieve this with one staff person. The cost of that staff person is minuscule compared with the cost of caring for the number of high-risk births we could anticipate from these very young girls. There is endless funding to repair the wounded lives of these babies having babies. Yet, this program, which demonstrably prevents the tragedy, only exists as long as we are able to consistently identify outside private funding support.

Another low-cost, but highly effective program addresses the serious and far-reaching problem of low-birthweight babies. A few years ago, the State of Illinois funded a case-management program at Mount Sinai known as the Problem Pregnancy Program. Through this program, a case manager is assigned to women who have all been identified at high risk for adverse pregnancy outcomes -- low birthweight, premature birth, and other problems. The case manager's job is to ensure that women in this program receive appropriate medical services, as well as other support services they may need throughout their pregnancy. Simply by involving these women in their care, and making sure that they received the services they need, we found we had a program in which not one of the 150 women in the program delivered a low birth weight infant.

These are just two examples of programs that are common-sense responses to serious health and social problems. Unfortunately, these are the types of programs that do not receive significant support. They are not automatically built into any public or private reimbursement system. They certainly do not add to a hospital's profit margin. They certainly do not gain a hospital the professional distinction accumulated by sitting back and catching the problems with expensive high tech services. And, too often, they are programs offered only by institutions such as ours that do not have the financial resources to guarantee their continuance.

I appreciate the opportunity to tell you about our community. Its problems are those of many communities throughout the country. We believe that there are solutions to those problems, and that they can be achieved, with creativity, common sense and commitment to the people of these communities. Thank you.

MOUNT SINAI HOSPITAL MEDICAL CENTER

DEPARTMENT OF FAMILY AND COMMUNITY HEALTH SERVICES

MISSION

The DEPARTMENT OF FAMILY AND COMMUNITY HEALTH SERVICES serves as a catalyst that enables the family to improve its health status. This is achieved through the provision of quality reproductive health services, educational and nutritional services to women of childbearing age and their families. The Department provides mechanisms that facilitate the family's access to health services and community resources. To that end, the following program services are offered:

FAMILY SERVICES:

PARENTS TOO SOON PROGRAM provides comprehensive medical/health/social case management services to pregnant and/or parenting adolescents who reside within the North Lawndale, East Garfield, West Garfield, and Near West community areas. Services are also provided to young men, ages 10-15. Funded by Illinois Department of Public Health.

PROBLEM PREGNANCY PROGRAM provides case management services to pregnant women receiving prenatal care at Mount Sinai Hospital Medical Center. Funded by Illinois Department of Public Health.

SUBSEQUENT PREGNANCY PROGRAM provides intensive in-home case management services to adolescents who have only had one child. Services are directed towards assisting the adolescent mother develop goals and learn how those goals can be achieved. Development and strengthening of parenting skills also takes place. Funded by Illinois Department of Public Health.

THE FRESH START PROGRAM provides outpatient treatment for low income women who are pregnant and/or parenting and have alcohol or drug-related problems. Fresh Start focuses on developing a chemical-free lifestyle and improved parenting skills. It is a 24 week program, and includes weekly home visits, group counseling and support groups, daycare services, parenting and prenatal classes. Funded by Department of Health & Human Services, Washington, D.C.

DRUG FREE FAMILIES WITH A FUTURE PERINATAL FACILITATOR/PERINATAL CENTER PROGRAM provides identification, needs assessment and referral services for pregnant and/or parenting women with children one (1) year or under, who have a history of substance abuse. Funded by the Perinatal Center-Rush Presbyterian St. Luke's Hospital Medical Center.

NUTRITIONAL SERVICES:

WIC PROGRAMS provides supplemental nutrition for women, infants and children who are eligible for services. 7,800 clients can be served on a monthly basis by Mount Sinai Hospital Medical Center. Funded by Illinois Department of Public Health.

HEALTH SERVICES:

REPRODUCTIVE HEALTH PROGRAMS provides family planning/educational services to adolescent girls and women who are of low or limited income. Limited health education services are provided to young men. No one is denied services due their inability to pay. Funded by Illinois Department of Public Health.

PARTNERSHIP IN HEALTH PROGRAM provides casemanagement/health care services for patients under an agreement with the Chicago Department of Health who warrant more intensive and specialized care and follow-up than can be provided in CDOH centers. PIH patients fall under the following categories of service: "increased risk" OB patients who receive prenatal and postpartum care, pediatric and consultations, mammograms. Funded by Chicago Department of Health.

EDUCATIONAL SERVICES:

THE PARENTING INSTITUTE provides coordinated parenting education services to the entire Chicagoland and metropolitan area. Classes are offered in several locations in conjunction with community colleges, high schools, and community-based social service agencies. The goal is to provide parents with the skills, knowledge, and resources they need to rear children in our complex society. Each component of the program is taught by a highly respected professional who is an expert in his/her field. Each is sensitive to the varying needs and cultures of the participants and clients served.

COMMUNITY SEX EDUCATION TRAINING PROGRAM provides a comprehensive adolescent reproductive health education 28 hour curriculum for human service professional and paraprofessional. A Certificate and Continuing Education Units are awarded upon successful completion of the program. Additionally, the

WINDOW OF OPPORTUNITY SCHOOL-BASED TRAINING PROGRAM offers a comprehensive developmentally appropriate reproductive health education program to 4th through 8th grade students. The School-Based Program is currently funded by the The Perinatal Center, and the Marshall Fields Foundation.

PARENTS TOO SOON GED/EDUCATIONAL PROGRAM provides educational services to participants within the Parents Too Soon Program. Funded by Illinois Department of Public Health.

INSIGHT SPEAKER'S BUREAU PROGRAM provides free on-site prevention education services for community residents and agencies. This is a joint project between Mount Sinai Hospital Medical Center and the Perinatal Center-Rush Presbyterian St. Luke's Medical Center.

MOUNT SINAI HOSPITAL MEDICAL CENTER PROGRAMS FUNDED BY THE ILLINOIS DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

MOUNT SINAI BASED PROGRAMS

CHILD INTERVENTION
Screening, assessment and supportive services to severely emotionally disturbed children and adolescents that reside in community areas 30 and 31.

PSYCH INTERVENTION
Psychiatric assessments to determine least restrictive service.

MOUNT SINAI COMMUNITY MENTAL HEALTH CENTER

ADULT
Adult outpatient psychiatric services to community area 78 residents.

DAY TREATMENT
Adult day milieu psychiatric services to community area 78 residents.

HOME PSYCARE
Brief in home psychiatric services to adults unable to attend outpatient care due to their mental illness.

CHILD/ADOL PSYCH
Child and adolescent outpatient psychiatric service to community area 30 and 31 residents.

MENDAC
State wide outpatient mental health assessment and treatment services to the hearing impaired. Major component is consultation, training and technical support to agencies working with the mentally ill, hearing impaired.

MILE SQUARE BASED PROGRAMS

ADULT
Adult outpatient psychiatric services to community area 28 residents.

YOUTH & FAMILY
Child and adolescent outpatient psychiatric service to community area 28 residents.

SASS NEAR WEST
Screening, assessment and supportive services to severely emotionally disturbed children and adolescents that reside in community area 28.

DIAGNOSTICS
Assessment and referral services to developmentally disabled residents of community area 28.

MILIEU/SUPPORT
Adult day milieu psychiatric services to community area 28 residents.

PIONEER HOUSE
Adult psychiatric crisis care in a residential settings.

LAN BANKER & PAS AGENT
Adult psychiatric triage and crisis intervention.

DMH BANK
A revolving fund that provides rent, food, clothing or help with other expenses, when such help prevents a psychiatric hospitalization or facilitates a discharge from a psychiatric facility.

MOUNT SINAI HOSPITAL MEDICAL CENTER

Our Mission

Mount Sinai Hospital Medical Center is committed to the health and well-being of all those we serve. We accomplish this through:

- efficient and compassionate delivery of quality health care to our patients, regardless of their ability to pay;
- continuous improvement in the quality of the care and service we provide;
- leadership that involves and empowers our local communities in the development, advocacy and implementation of innovative solutions to problems that affect social, economic and individual health and well-being;
- education and training of physicians and other health care professionals to ensure the future availability of comprehensive health services for our patients; and
- basic and applied research relevant to the health care needs of our communities.

Our Beliefs

In accordance with the values of Mount Sinai Hospital's Jewish heritage, we believe that:

- Health care is a right, not a privilege. A fair and equitable health care system should be available to everyone.
- We have a moral obligation to serve our patients, our communities and each other with quality care, compassion and respect for all.
- Our services must be directed by the needs of our communities.
- The staff of our hospital — employees, physicians, students and volunteers — are fundamental to the accomplishment of our mission. We are committed to their well-being and their personal and professional growth.
- The individuality and multi-cultural diversity within our institution and within our communities should be celebrated. Achieving an environment enriched by fairness, equity and mutual respect among all people is essential to accomplishing our mission.

Adopted: February 28, 1992

Mr. MCNULTY [presiding]. On behalf of Chairman Rangel, I want to thank all of you for your testimony. As you know there is a vote going on right now, and thanks to Mr. Hoagland we were able to allow you to continue with your testimony. He stayed here while I went over to vote, and now he is going to vote, so I want to thank him for his cooperation.

Mr. Martinez, you mentioned in your testimony that New York plans to undertake a new initiative to improve community hospitals throughout the State. Do you envision that many of these centers will be financed with tax exempt financing under current law or do they need the kind of change you are suggesting in your testimony in order to do so?

Mr. MARTINEZ. Ideally, they need the kind of change that we are suggesting. The alternative is that they can be financed, but the cost of financing is higher, and our concern is that it contributes, then, to the potential that they are then going to face foreclosure. Obviously, if you can provide the lowest possible cost where you are looking at providing a health care center in an inner city environment, that is going to help their survivability.

Mr. MCNULTY. How can we ensure that these facilities will be located in the most needy communities?

Mr. MARTINEZ. I believe you know that New York is one of the most highly regulated health care systems in the country, and in order for these facilities to be developed they must go through a review process with the State Department of Health and receive concurrence from that Department of Health. One of the criteria is to ensure we will provide this type of facility in areas where the need is the greatest. We know we need to get people into community-based health care centers as opposed to using the emergency room as their primary care facility.

Mr. MCNULTY. Thank you. Mr. Gage, you presented some very stunning new statistics in your testimony. I was just wondering how you perceive these proposals for universal coverage impacting the problems that you outlined in your testimony.

Mr. GAGE. Well, I think from our perspective it certainly can't happen soon enough, and we are looking forward to enactment in the very near future, probably next year. The problem is, it is also clear that health reform is a costly initiative that will be phased in over a long period of time. It is probably unlikely that the rates that will be paid under health reform will be adequate to support a lot of the standby services like trauma centers, burn care and neonatal intensive care that are going to be needed in urban areas. So we are very concerned about having additional resources available as there are now under the current system.

We are very pleased that Chairman Stark of the Health Subcommittee introduced legislation last week that would, in fact, address some of those problems. We do think that this committee has worked with us very well in the past, and we would look forward in the future to continuing to do so.

Mr. MCNULTY. You mention the cost of health care reform. That is something that we are all very concerned about, particularly the up-front cost. Because as we get further down the road toward implementation, we can save a lot of costs as far as the so-called health care bureaucracy is concerned, but as we move toward that,

we need some money up front to provide the coverage to those who are uninsured and underinsured.

So do you have a particular preference for any of the plans that you have heard about so far, or the funding mechanisms that might be used?

Mr. GAGE. Well, I don't know that we have a preference. We certainly want to make sure that it is adequately funded and not simply funded through efforts to transfer existing costs around the system. There—as other witnesses have pointed out, there is a tremendous pent-up need for preventive and primary health services, so many of the people who are going to come into the system for the first time with some form of insurance are going to be very heavy users of health care. These are the people right now who often delay care until they have an emergency and end up in the emergency room. So new resources are clearly going to be needed.

We endorsed the so-called "sin taxes" to pay a portion of the bill. We certainly believe that there needs to be a sharing of employer revenues, either through a premium or tax mechanism like the Social Security Act, which I understand is under consideration; or through the taxing of benefits or setting a tax cap on the deductibility of the so-called "Cadillac plans."

There are quite a few funding mechanisms that have been on the table that we certainly find appealing, but we do believe there are going to need to be additional tax revenues. It can't all be funded out of resources that are already in the system.

Mr. MCNULTY. We are going to really need, if we are going to move toward some kind of a universal plan, a lot of support as far as implementation is concerned, because as you know, the most controversial part of the program will be the funding mechanism.

Mr. Greenspan, you described the window of opportunity program. How much does this program cost and can you quantify how much money our system saves by reducing the numbers of pregnancies among these children?

Mr. GREENSPAN. The window of opportunity program required one full-time staff person. That was the entire direct expense of this program. At the time we initiated the program, that person cost us approximately $35,000. With all of the support attendant to it, the total cost of the program is probably about $45,000. The cost savings are titanic. When we went into the local grade school and we started the program with that, there were 15 pregnancies to young girls reaching down as low as the fourth grade. One adult participant in this program was a 20-year-old grandmother. We have to think about that for a minute.

We estimate that in the population slightly older than this, so that we are being conservative, at least 20 percent of the births to this population would be high-risk births that end up in a neonatal intensive care unit. That means three births per year. In a single year that is approximately $700,000 in direct cost for care for the infants. In addition, one child will probably end up in an institutional ward for a lifetime, costs measuring probably around $1 million.

Again, the cost of the program is about $42,000, $45,000, so that multiplier is enormous. And if you consider that the subsequent pregnancies to these children have been delayed 3 years, you begin

to multiply that expense that the State has saved. We count the dollars in multiple millions.

Mr. MCNULTY. That is very impressive. I want to thank you for your good work.

Commissioner Krueger, I want to thank you for your testimony. I just wanted to ask you if you wanted to share with the committee any real-life examples of how tax-exempt hospitals are not meeting their obligations to provide the benefits to inner-city residents.

Ms. KRUEGER. Mr. Chairman, in the State of Minnesota, in the metropolitan area of St. Paul-Minneapolis, we have two county hospitals. One had to seek legislative approval to go outside of its levy authority to raise additional dollars because the hospitals in the surrounding area are sending all their indigent patients to that particular county hospital.

I think that is a good example.

Mr. MCNULTY. I thank all of you for your testimony. We are grateful.

I ask the members of panel number 2 to kindly come forward.

Mr. Debye-Saxinger is also on this panel. Is he in the room?

[Due to scheduling conflicts, Mr. Debye-Saxinger was unable to present the statement of Mitchell Rosenthal of the Phoenix House Foundation. The prepared statement follows:]

Mitchell S. Rosenthal, M.D.
President
Phoenix House Foundation

It is impossible to avoid the issue of drug abuse in considering the distressed neighborhoods of this country, for drug abuse has become the most significant threat to the well being of those who live in these communities and to the social stability and economic viability of the communities themselves.

It is useful, in this regard, to realize how the problem of drug abuse has altered over the years.

When I began treating drug abusers in the mid-Sixties, the problem was defined, almost exclusively, in terms of heroin addiction, and we believed we were confronting a crisis that couldn't possibly worsen.

Of course, it did. In the years that followed, the nature of drug abuse in the United States changed, and its impact on our society increased. Drugs of abuse came to include a great variety of substances. Drug use spread throughout society and across the country. The problem was no longer confined to the streets. It reached the schools and the workplace and threatened even the most secure and comfortable homes.

It would be wrong to say that we were powerless to affect this rising tide of drug abuse. We developed predictably effective treatment methods. And we mounted broad public education and prevention programs that have been able to change attitudes and "de-normalize" drug use throughout much of the population.

Thus, there has been, during the past decade, a gradual but sustained decline in overall drug use in the United States.

Yet, as overall drug use has declined, heavy and high-risk use has increased. This heavy, high-risk use of the most disabling drugs -- heroin, cocaine, crack, methamphetamine -- strikes hardest at our nation's most vulnerable populations: the poor, the unemployed, the emotionally fragile, and the troubled young.

And what has become increasingly evident is the degree to which this drug abuse now drives our most intractable social problems. Not only crime but a long and troubling list that starts with homelessness and chronic mental illness and includes domestic violence, child abuse, and the spread of AIDS. Drug abuse is the canker at the core of our most troubled communities and least functional families.

When Los Angeles erupted in an outburst of senseless violence last year, what allowed normal societal restraints to slip was not only rage, resentment, and alienation, battered notions of self-worth, and the early death of dreams. It was also drug abuse -- drug abuse that had eroded family influence, rendered communities incapable of restraining aberrant behavior, and made violence the vocabulary of youth in America's inner cities.

Yet, when America's policy makers seek answers to the dilemma of urban unrest, they focus on remedies that, while appropriate, are by themselves inadequate. Better schools, housing, and health care, more effective job training, and incentives for the economic development of blighted urban areas. These are not "wrong" answers. They simply do not target the one variable in the equation of social disorder that is most amenable to change -- drug abuse.

Now, drug abuse is clearly not the only villain in our modern American tragedy. There have been enormous social and demographic changes over the past half-century, and many factors have contributed to the distress of inner city and other marginal communities. But, while drug abuse is not the sole cause of the social problems we face today, there is none we can successfully confront without taking on drug abuse first.

Better schools will not help adolescents who have dropped out of school or arrive in class high. Job training will not lead to employment for young people whose lives are directed by drugs. More public housing will not necessarily help alleviate inner city blight, not when addicts prowl the housing projects and drug dealers rule them. Nor can we hope to meet the health care needs of our inner cities without recognizing and responding to the fact that the physical ills of many patients there are directly attributable to their substance abuse.

This is no small number. One major hospital center in New York estimates that 51 percent, more than half, of the adults admitted to inpatient units are substance abusers.

Heavy and high risk drug use takes a tremendous physical toll and exposes abusers to a wide range of disorders. Yet hospitals will ignore the abuse while they deal with the consequences: seizures and blackouts, unlikely infections and impaired liver function. They will repeatedly treat the chronic asthma or bronchitis of crack addicts without ever addressing their use of crack.

There is no way we can deal with urban America's health care needs or, indeed, successfully confront any of its problems, without coming to grips with drug abuse. Neither can we restore these communities to health unless we are able to salvage dysfunctional families there.

The greatest single failure of social policy in the United States is the growing number of damaged, disruptive, and dysfunctional families. The most glaring evidence of this is the impoverishment of youth. For the number of Americans living beyond the boundary of family economic viability, below "the poverty line," is growing and growing younger.

For a vast number of impoverished American families dependency is rooted in dysfunction that derives, in whole or in part, from drug abuse.

While we do not yet know the exact degree to which drug abuse is responsible for family dysfunction, we have ample evidence of the significant role it plays in almost every area of disordered behavior. And, at Phoenix House, we recently made some disturbing discoveries about the families from which our adolescent residents come.

In a study of abuse and neglect among more than 200 of our adolescent residents, 90 percent reported some form of early abuse. Nearly 60 percent reported sexual abuse, more than 45 percent physical abuse, and close to 75 percent reported what could only be considered serious emotional abuse or neglect.

Family profiles were close to what we expected. Nearly 80 percent of these youngsters came from broken homes. Close to 45 percent were on welfare. More than 40 percent reported that parents had problems with the law or were in prison, and no less than 75 percent had parents who were substance abusers.

Although the connection between substance abuse and family dysfunction is hard to ignore, that is exactly what government policy and social service agencies in the United States tend to do. Indeed, it is not an exaggeration even to say that government "enables" the drug abuse of dependent families.

Rarely does drug use threaten the ability of drug abusers to secure welfare, housing, food stamps, or any other form of public assistance. Even as drug-related disordered behavior creates vast new problems for social service agencies, the priorities of these agencies tend to minimize awareness of drug use.

Relocating the homeless takes precedence over addressing their drug dependence. Reuniting mothers with their drug-exposed infants is often given greater weight than dealing realistically with maternal drug abuse. In these ways, social policy in the United States today can be said to subsidize pathology.

We cannot fault our colleagues in social services for focusing on "service". It is, after all, what they do. And we cannot argue the need for more resources in our distressed communities: more investment in education, housing, health care, job training, and economic development.

But just as evident is the need to address the dysfunction of dependent families in ways that respond to drug abuse.

So, I would ask the subcommittee as they seek new resources to remedy the problems of this country's distressed neighborhoods to recognize the centrality of drug abuse.

There is need for a federal drug abuse policy that responds to this reality, and for resources that will support aggressive demand reduction initiatives targeting high-risk use, disordered abusers and those communities where drug abuse is most persistent and most pernicious.

Prevention and local law enforcement need be part of these demand reduction efforts. But the key to bringing high-risk use under control, and arresting the spread of drug-related disordered behavior, is treatment.

Now, treatment doesn't always work. And not all treatment works as well as we might like. But predictably effective forms of treatment do exist.

Research makes clear, for example, that the therapeutic community's long-term residential regimen is both effective and highly cost-effective. And it is the treatment of choice for nearly two million disordered drug abusers in the U.S.

And yet there are today few more then eleven thousand of these long-term residential treatment beds in the entire country.

So, if you ask me what we most need to alleviate the distress of America's most troubled neighborhoods. I'd say more long-term treatment beds.

How many ?

Well, a hundred thousand wouldn't be too many.

But what we need first is to recognize drug abuse for the enemy that it is, to develop a federal drug policy that reflects that recognition, and to allocate resources that respond to it.

Thank you.

Mr. MCNULTY. We will begin with testimony from Gretchen Berzin, from SEIU.

STATEMENT OF GRETCHEN BERZIN, R.N., JACKSON MEMORIAL HOSPITAL, MIAMI, FLA., ON BEHALF OF SERVICE EMPLOYEES INTERNATIONAL UNION, AFL–CIO, LOCAL 1991

Ms. BERZIN. Good afternoon. My name is Gretchen Berzin. I am a Registered Nurse, and I am a member of the Service Employees International Union Local 1991 in Miami, Fla. I currently work at the bedside in a critical care unit.

Mr. Chairman, I submitted a written statement and request that it be included in the record of this hearing.

Mr. MCNULTY. Without objection, the testimony of all of the witnesses will be made a part of the permanent record.

Ms. BERZIN. For the past 2 years, SEIU Local 1991 has represented over 2,000 registered nurses at Jackson. I am grateful to the subcommittee for this opportunity to express the concerns of my coworkers about the hazard of blood-borne infection through needlestick injuries. The hazard is not only to providers who use the needles, but also to everyone who works in patients' rooms or treatment areas and handles wastes and linens.

In our very first collective bargaining agreement between Local 1991 and the hospital, we negotiated a health and safety committee composed of equal numbers of labor and management representatives. I am a member of that committee. Because our union has fought for a role in medical device safety, R.N.s at Jackson Memorial can be actively involved in an effort to win better protection on the job.

Unfortunately, very few health care workers in the United States are able to do so. Like all frontline health care workers, the quality of patient care is the highest priority of the R.N.s at Jackson Memorial. Safety and quality care are closely linked.

Providers who work in fear of contracting a deadly blood-borne disease are less able to provide care of the highest quality. We can take better care of our patients when we know that our own health and safety is being taken care of. Needlestick injuries, which can lead to infection with blood-borne diseases like HIV and hepatitis B, are among our members' chief concern.

Management at JMH has responded on this issue, but we have yet to eliminate a number of unsafe devices at Jackson. We still have a long way to go, especially with the IV catheter. Many factors contribute to our lack of progress. There is confusion over how to evaluate devices. Some of my coworkers resist using new devices that require them to change old habits. In the face of uncertainty, hospital management hesitates to make the comprehensive conversion to safer devices that we believe is necessary.

Another problem that hinders our joint efforts to improve needlestick safety is the absence of good data. We do know that in the year ending in September, 1992, 261 needlestick injuries were reported at Jackson, although it is well-known that many needlesticks go unreported.

We merely have a number. We don't know what devices were implicated and how many involved blood-contaminated needles.

The hospital also has a product review and analysis committee. The union fought for representation on this committee, and I participate in the subcommittee on safety devices. We spent a lot of time on IV catheters, which are used to start IV lines. Once used, these devices are contaminated with blood. As a result, any worker that is stuck with a used IV catheter needle is very likely to be exposed to a patient's blood. Because of the obvious hazard, this was the first device category that we tackled. Unfortunately, these trials are conducted without any real criteria for evaluation.

There are two companies that produce safer versions. Over the past year, trials have been conducted with both devices. The response to the first device was mixed, although it was effective in preventing injury. Some of the departments liked it, but there were also some complaints. Because the device protected us from needlesticks, the union recommended that the device be adopted hospital-wide and that use of the existing unsafe devices be stopped. Instead, management decided simply to make the use of the safer device optional. Out of habit and in the absence of adequate in-service training, many nurses still use the old device.

Then the subcommittee decided to evaluate the other company's device. The trials were a great success on the special immunology floor where needle safety is a big concern. Once again, the union recommended its adoption hospital-wide. Instead, management has proposed further trials. Meanwhile, health care workers continue to work in daily fear of injury and infection.

Even when we finally win on IV catheters, we will have to go through the same drawn-out process with other unsafe devices. What we really need at our hospital is a comprehensive needlestick program that includes effective injury monitoring and procedures for assessing new technology.

We have spent over 1 year trying safer IV catheters. That is frustrating because the devices are available. They have been approved for use in hospitals, and they are already past the first generation catheter. Management could have brought in a safe IV catheter for hospital use and then trailed future improvements, but they haven't.

I would like to reiterate a very important point, and that is that every needlestick is a serious event; 261 needlesticks should not be tolerated.

What we need from the Federal Government is leadership. I support H.R. 1304 because it requires the Food and Drug Administration to develop performance safety standards for needle-bearing medical devices.

On behalf of over 2,000 R.N.s at Jackson Memorial Hospital, I would like to thank you for holding this hearing today. It is an important step toward gaining the basic safety protections that all health care workers need and deserve.

I have brought some safer devices to show you, if you care to look at them, to prove my point that they are available. They are available in many different ways. These used to be glass, now they are plastic. Our hospital has gone ahead with these. They have gone ahead with devices such as this, as well, that are easy to buy and probably inexpensive. This attaches the IV line to the port, and

then it doesn't have a needle anymore; it really has a recessed little lower bearing point on it.

There are also diabetics that have to check their blood for a serum glucose. They use this. The needle is actually recessed back in this once they puncture their finger.

There are also syringes that are available that actually lock down on the needle. You give the injection, whatever, and then this sheathing device actually comes, the red meaning bad, comes up over and protects the needle.

This is another piggyback device where the solution is put in here and then this area here is protected.

This is a needle that they use in pediatrics a lot, where it has an IV that goes into the patient and then this sheath, when it is pulled out, goes over the needle and protects the catheter.

We also have, once the needle comes out of the IV tubing, such things as this, just to protect, take the needle off and protect the tubing.

This is another example. IV tubing goes on the end of this, then this is piggybacked into the IV line. This again is not a needle anymore. Hopefully, in my career I will see no needles, there will actually be these little plastic blunt devices.

The device that we are working the hardest on, which we can't convince management to use totally and get rid of all unsafe devices, is this IV catheter, which if you insert it in the patient, you need a needle to insert it through the skin and a plastic catheter goes into the patient. I have to pull the needle out of the patient. That has blood in it. And what happens is then when you pull this out, this is protected, the whole needle is protected.

So there definitely are devices available for hospitals to purchase and protect their employees.

Mr. MCNULTY. What about devices that could not be used even if you wanted to reuse them, that would lock. A syringe, for instance, that could not be reused, do you have something like that?

Ms. BERZIN. Yes, that was this one right here; this locks, couldn't be reused.

Mr. MCNULTY. And that is currently available?

Ms. BERZIN. This is available. Well, Monojet makes the one that our hospital has purchased. Right now it only comes in a 3 cc. size. We are still waiting for the 5 cc. and the 10 cc. But Becton-Dickinson actually has all sizes.

Mr. MCNULTY. Are you using that now?

Ms. BERZIN. We are using it in one size. We are still discussing or getting into the hospital the larger sizes, all sizes.

Mr. MCNULTY. Thank you. We may wish to keep some of those for the committee file, if that is all right.

Ms. BERZIN. Sure.

Mr. MCNULTY. Thank you.

[The prepared statement follows:]

STATEMENT OF GRETCHEN BERZIN, R.N., LOCAL 1991, SERVICE EMPLOYEES INTERNATIONAL UNION

My name is Gretchen Berzin. I am a registered nurse and a member of SEIU Local 1991. I have worked for Jackson Memorial Hospital (JMH) in Miami, Florida, for twenty-four years.

I currently work at the bedside in the critical care unit. Jackson Memorial is a 1,400-bed hospital -- the second-largest in the United States.

For the past two years, SEIU Local 1991 has represented over 2,000 registered nurses at JMH. I am grateful to Chairman Rangel and the other members of the subcommittee for this opportunity to express the concerns of my co-workers at JMH about the hazard of bloodborne infection through needlestick injuries. The hazard is not only to providers who use the needles, but also to everyone who works in patient rooms and treatment areas or handles waste and linens.

In our very first collective bargaining agreement between Local 1991 and JMH, we negotiated a health and safety committee composed of equal numbers of labor and management representatives. I am a member of that committee.

Because our union has fought for a role in medical device safety, RN's at Jackson Memorial can be actively involved in the effort to win better protection on the job. Unfortunately, very few healthcare workers in the United States are able to do so.

Like all frontline healthcare workers, the quality of patient care is the highest priority of the RN's at Jackson Memorial. Safety and care quality are closely linked. Providers who work in fear of contracting a deadly bloodborne disease are less able to provide care of the highest quality. We can take better care of our patients when we know that our own health and safety is being taken care of.

Needlestick injuries, which can lead to infection with bloodborne diseases like HIV and hepatitis B, are among our members' chief concerns.

Management at JMH has responded on this issue, but we have yet to eliminate a number of unsafe devices at JMH. We still have a long way to go, especially with the IV catheter.

Many factors contribute to our lack of progress. There is confusion over how to evaluate devices. Some of my co-workers resist using new devices that require them to change old habits. In the face of uncertainty, hospital management hesitates to make the comprehensive conversion to safer devices that we believe is necessary.

Another problem that hinders our joint efforts to improve needlestick safety is the absence of good data. We do know that in the year ending in September 1992, 261 needlestick injuries were reported at JMH -- although it's well known that many needlesticks go unreported. However, we don't know what devices were implicated and how many involved blood-contaminated needles.

The hospital also has a Product Review and Analysis Committee. The union fought for representation on that committee. I participate in the subcommittee on safety devices.

Our experience with IV catheters illustrates the need for leadership from the Food and Drug Administration and other federal agencies on the needle safety problem.

We have spent a lot of time on IV catheters which are used to start IV lines. Once used, these devices are always contaminated with blood. As a result, any worker that is stuck with a used IV catheter is very likely to be exposed to a patient's blood. Because of the obvious hazard, this was the first device category we tackled Unfortunately, these trials are conducted without any real criteria for evaluation.

There are two companies that produce safer versions. Over the past year, trials have been conducted with both devices. The response to the first device was mixed, although it was effective in preventing injury. Some departments liked it but there were also some complaints.

Because the device protected us from needlesticks, the union recommended that the device be adopted hospital-wide and that use of the existing, unsafe device be completely stopped.

Instead, management decided simply to make use of the device optional. Out of habit and in the absence of adequate in-service training, many nurses use the old device.

Then the subcommittee decided to evaluate the other company's device. The trials were a great success in the immunology department where needle safety is a big concern, for obvious reasons. Once again, the union recommended its adoption hospital-wide. Instead, management has proposed further trials. Meanwhile, healthcare workers continue to work in daily fear of injury and infection.

But even when we finally win on IV catheters, we'll have to go through the same drawn-out process with the other unsafe devices. What we really need at JMH is a comprehensive needlestick program that includes effective injury monitoring and procedures for assessing new technology.

We have spent over a year conducting trails for a safe I.V. catheter. It's frustrating because the safety devices <u>are</u> available. These devices have been approved for use in hospitals and the technology has already developed past the first generation. Management could have brought in a safe I.V. catheter for hospital-wide use and then conducted trails as the devices were improved, but they have chosen not to.

In conclusion, I would like to emphasize that <u>every</u> needlestick is a serious event. 261 needlesticks should not be tolerated.

What we need from the federal government is leadership. I support H.R. 1304 because it requires the Food and Drug Administration to develop performance safety standards for needle-bearing medical devices. FDA action on this issue is long overdue.

SEIU petitioned FDA to take such steps more than two years ago and has yet to receive a formal response from the agency.

On behalf of over 2,000 RN's at Jackson Memorial, I would like to thank you, Chairman Rangel, for holding this hearing today. It's an important step towards gaining the basic safety protections that all healthcare workers need and deserve.

Mr. MCNULTY. Next Peggy Luebbert; is that correct?

Ms. LUEBBERT. That is right.

Mr. MCNULTY. From the American Society of Medical Technology.

Ms. LUEBBERT. Good afternoon. My name is Peggy Luebbert, and I am an epidemiology safety manager——

Mr. MCNULTY. Excuse me, perhaps I will have my colleague, Mr. Hoagland, say a word first before you begin.

Mr. HOAGLAND. Well, I would, Mr. Chairman, like to welcome Ms. Luebbert to the committee. She works in Fremont, but she does live in Omaha.

And it is good having you back here, Peggy. I am looking through my pile here to try and find your testimony so I can follow it. Anyway, welcome to the committee and I am glad you are here representing Nebraska.

STATEMENT OF PEGGY PRINZ LUEBBERT, EPIDEMIOLOGY/SAFETY MANAGER, MEMORIAL HOSPITAL OF DODGE COUNTY, FREMONT, NEBR., ON BEHALF OF THE AMERICAN SOCIETY FOR MEDICAL TECHNOLOGY

Ms. LUEBBERT. Thank you. I appreciate the opportunity.

As I said, I am an epidemiology safety manager at Memorial Hospital of Dodge County, located in Fremont, Nebraska. In my position at the hospital I am responsible for evaluating and monitoring safety issues associated with new products, as well as following up with all body fluid exposures. I appear before you today on behalf of the American Society of Medical Technology to articulate ASMT's support for H.R. 1304, legislation that promotes safer needle products.

ASMT's membership of over 20,000 nonphysician clinical laboratory scientists consider needle safety a serious issue. In most health care settings, these laboratory professionals are the individuals who handle needles and other sharps when they draw your blood and analyze it in the clinical lab.

For example, it is not unusual for a phlebotomist, the one who draws your blood, to use 50 open-bore needles during her daily rounds. These open-bore needles that contain a quantitative amount of fresh blood have been associated with too many occupational acquired infections of both hepatitis and HIV.

Many studies demonstrate vividly the extreme risk that laboratory professionals are placed at on a daily basis when handling needles and other sharps. In the Center for Disease Control and Prevention's May issue of HIV and AIDS surveillance report, they note that 14 of the 36 documented known cases of HIV infection reported to CDC were from clinical laboratory professionals.

ASMT believes that this is just the tip of the iceberg. Many workers do not bother to report exposures due to the hassle of the process, the loss of their personal privacy, and due to simple fear of the unknown. This report demonstrates vividly the extreme risk that laboratory professionals are placed at on a daily basis.

Also, recently, ASMT surveyed clinical lab managers and supervisors across the Nation on a variety of issues. Approximately 45 percent of those surveyed responded. One survey question addressed the issue of how many labs have clinical laboratory profes-

sionals collecting specimens. Of the 2,700 managers and supervisors who returned the survey, 63 percent responded that clinical lab practitioners were collecting specimens.

Although accidental needlesticks can and do occur at various stages of the testing process, most occur at the point of the specimen collection. This data shows clearly that clinical laboratory professionals are performing a majority of the specimen collections for the lab and therefore are susceptible to accidental needlestick injuries in the course of performing their normal duties.

ASMT strongly supports the development of medical device assessment standards, especially for those devices that hold the possibility of exposure to infectious diseases. Organizations such as the National Committee for Clinical Lab Standards and individuals like Dr. Janine Jagger of the University of Virginia have initiated work in this area.

ASMT urges that standards for safer needle products be developed in cooperation with manufacturers, clinical laboratory professionals, and other health care workers who are at direct risk of exposure.

Due to the fact that the Food and Drug Administration already handles the approval of all medical devices, ASMT believes that the FDA is the proper location for the development of assessment standards for needles used in the health care setting. Exposure to blood through a needlestick is probably one of the most traumatic and terrifying events that a health care worker may have to endure. I think if you went and asked health care workers who have had an exposure, they could give you, no matter how long ago it was, the exact details of who it was, where it was, and how it occurred.

There are conservative estimates that over 800,000 exposures occur each year in hospitals throughout the United States. This number is conservative when you consider that some two-thirds of all exposures are not reported.

Let me take the time to run through a typical scenario of what happens in a clinical setting each and every time one of these 800,000 needlesticks occurs. From the laboratory point of view, the majority of the sticks or exposures occur when the sample is being obtained on the floor from the patient. When the stick occurs, the procedure needs to be interrupted so that the worker can get immediate first aid. Quality health care is put on hold while the worker then spends the next few hours with the occupational health service of the facility, completing the paperwork, the documentation of the exposure, reviewing his or her vaccination history and immune status, doing baseline lab work, and most importantly, receiving counseling.

As you can imagine, at this point, we now have a very distraught employee. He or she has previously received education about what this event could possibly mean, and now realizes that their life could be changed forever.

Employees are asked to return for additional lab work in 6 weeks, 3 months, 6 months, and sometimes up to 1 year. During this time, they are counseled to warn anyone who may come in contact with their body fluids of potential risk. This includes their dentist, their physicians, and most importantly, their spouse. While an

employee is trying to deal with this, it is not unusual for them to go weeks and even months without telling their spouse what has happened. They are having a hard time dealing with it themselves, and they don't know how they could handle dealing with the family setting as well.

Meanwhile, back at the hospital, we are now spending hours working with Workman's Compensation, sometimes changing staffing patterns around, and always following up on the original-source patient. This patient should also be considered a victim in these situations.

We are required after an exposure to interview and request from these patients lab work to verify their status as to the blood-borne diseases. We have to document that they understand what we are doing and the potential consequences of this lab work. Many get confused as soon as you mention the word AIDS, and we have to spend time trying to convince them that they are not the one who is at risk from this episode. By the time the followup is complete, after one exposure, the facility may incur up to $1,500 in treatment costs for a nonserious exposure. You multiply this by the 800,000 estimated exposures a year, and you can see that we can spend up to $1.2 billion in treatment costs alone for nonserious exposures.

You must also consider the costs of a serious exposure. One HIV seroconversion claim can go as high as $500,000. This does not include moneys spent on increased self-insured retention, replacement of the lost worker, possible OSHA fines, liability insurance cost increases, legal fees, public relation costs, and recruitment costs.

The tragedy is that all of this could have been prevented had the health care worker had access to effective, safe needle products.

Although H.R. 1304 focuses on the development of safer needles in the health care setting, ASMT also urges that assessment standards for other hazardous medical devices in the clinical lab be developed to ensure the safety. Areas of attention must include glass specimen tubes, glass pipettes, vacuum tubes and capillary tubes. Each of these devices plays an integral role in lab testing and holds safety risks for the clinical laboratory professional.

ASMT at this time would like to thank Representative Pete Stark for introducing this legislation that can improve the environment we work in daily. ASMT would also like to thank Chairman Rangel for cosponsoring this legislation and for holding this insightful hearing today.

Thank you for this opportunity to appear before the committee this afternoon.

Mr. McNULTY. Thank you very much for your testimony.

[The prepared statement follows:]

STATEMENT OF PEGGY PRINZ LUEBBERT, CLS(NCA), MT(ASCP), SC, CIC, EPIDEMIOLOGY/SAFETY MANAGER, MEMORIAL HOSPITAL OF DODGE COUNTY, FREMONT, NEBRASKA, ON BEHALF OF THE AMERICAN SOCIETY FOR MEDICAL TECHNOLOGY

Good afternoon Chairman Rangel, Distinguished Members of the Committee, Ladies and Gentlemen:

My name is Peggy Luebbert. I am an Epidemiology and Safety Manager at Memorial Hospital of Dodge County located in Fremont, Nebraska. In my position at the hospital, I am responsible for evaluating and monitoring safety issues associated with new products as well as following up with all body fluid exposures. I appear before you today on behalf of the American Society for Medical Technology (ASMT) to articulate ASMT's support for H.R. 1304, legislation that promotes safer needle products.

ASMT is the nation's oldest and largest non-physician organization representing some 20,000 clinical laboratory professionals across the country. The society's primary missions are to improve the public's health and safety through the promotion of efficient and effective use of laboratory testing, effective standards of practice, and provisions of continuing education to improve competency of practitioners in laboratory science.

ASMT's membership consider the safety of needles and other sharps in the laboratory as a very serious issue. In most health care settings, these laboratory professionals are the individuals who handle needles and other sharps when they draw your blood and analyze it in the clinical laboratory. For example, it is not unusual for a phlebotomist, the one who draws your blood, to use 50 open bore needles during morning rounds. These open bore needles, that contain a quantitative amount of fresh blood, have been associated with too many occupationally acquired infections of both Hepatitis B and HIV.

Many studies demonstrate vividly the extreme risk that laboratory professionals are placed at on a daily basis when handling these needles and other sharps. In the Centers for Disease Control and Prevention's May issue of HIV/AIDS Surveillance Report they note that 14 of the 36 documented known cases of HIV infection reported to CDC were from clinical laboratory professionals. The report also lists 12 HIV infection cases, associated with clinical laboratory professionals, that CDC believes were "possibly" occupationally acquired. ASMT believes that this is just the tip of the iceberg. Many workers do not bother to report exposures due to the hassle of the process, loss of their personal privacy and due to simple fear of the unknown. This report demonstrates vividly the extreme risk that laboratory professionals are placed at on a daily basis.

A needlestick injury study conducted by the Centers for Disease Control for the years between 1983 and 1988 found 1,201 reported blood exposures to the HIV virus. Of those exposures 80 percent had been caused by needlestick injuries.

Recently, ASMT surveyed clinical laboratory managers and supervisors across the nation on a variety of issues. Approximately 45 percent of those surveyed responded. One survey question addressed the issue of how many laboratories have clinical laboratory practitioners collecting specimens. Of the 2700 managers and supervisors who returned the survey, 63.2 percent responded that clinical laboratory practitioners were collecting specimens for the laboratory. Although accidental needlesticks can and do occur at various stages of the testing process, most occur at the point of specimen collection. This data shows clearly that clinical laboratory professionals are performing a majority of the specimen collection for the laboratory and thus are susceptible to accidental needlestick injuries in the course of performing their normal duties.

Currently, it is difficult to determine the safety and effectiveness of needle products on the market. ASMT strongly supports the development of medical device assessment standards, especially for those devices that hold the possibility

of exposure to infectious diseases. Organizations such as the National Committee for Clinical Labotory Standards (NCCLS) and individuals like Dr. Janine Jagger, Associate Professor of Neurosurgery at the University of Virginia, have initiated work in this area. ASMT urges that standards for safer needle products be developed in cooperation with an outside advisory council to include NCCLS, Dr. Jagger, manufacturers, clinical laboratory professionals and other health care workers who are directly at risk of exposure to infectious disease due to accidental needlesticks.

Due to the fact that the Food and Drug Administration (FDA) already handles the approval of all medical devices, ASMT believes that the FDA is the proper location for development of assessment standards for needles used in the health care setting. While ASMT has some concerns regarding the Center for Devices and Radiological Health (CDRH) at FDA, the part of the agency that approves and regulates medical devices, we are hopeful that CDRH can utilize its experience and work effectively to develop needle assessment standards in a timely fashion. ASMT is encouraged by the FDA's recent announcement that a number of reforms will be implemented at CDRH to improve the speed of reviews of new medical devices.

An exposure to blood through a needlestick is probably one of the most traumatic and terrifying events that a health care professional may have to endure. Conservative estimates are that over 800,000 of these exposures occur each year in hospitals throughout the United States. This number is conservative when you consider that some two-thirds of all exposures are not reported.

Let me take the time to run through a typical scenario of what happens in a clinical setting each and every time one of these 800,000 needlesticks occur. The majority of exposures occur when the sample is being obtained on the floors from the patient. When the stick occurs, the procedure needs to be interrupted so that the worker can get immediate first aid. Quality health care is put on hold while that worker spends the next few hours with the Occupational Health Services of the facility completing documentation of the exposure, reviewing his/her vaccination history and immune status, doing baseline laboratory work, and most importantly receiving counseling. As you can imagine at this point, we now have a very distraught employee. He/she has previously received education about what this event potentially could mean and now realizes that their life may be changed forever. Employees are asked to return for additional laboratory work in 6 weeks, 3 months, 6 months, and sometimes up to a year. During this time, they are counseled to warn anyone who may come in contact with their body fluids of potential risks. This includes, their dentist, physician and most importantly spouse and loved ones. While an employee is trying to deal with this, it is not unusual for them to go weeks and even months without telling their spouse what has happened. The event is very dramatic and they simply cannot deal with it.

Meanwhile, back at the hospital we are now spending hours working with Workmen's Compensation, sometimes changing staffing patterns around and always following up on the original source patient. This patient should also be considered a victim in these situations. We are required after an exposure to interview and request from these patients lab work to verify their status to bloodborne diseases such as AIDS and Hepatitis. We have to document that they understand what we are doing and the potential consequences of this lab work. Many get confused as soon as you mention the word AIDS and we have to spend several hours trying to convince them that they will not get AIDS from this episode.

By the time the follow up is complete after one exposure, the facility many have incurred up to $1,500 in treatment costs for a non-serious exposure. You multiply this by the 800,000 estimated exposures a year, and you see that we

could spend $1.2 billion in treatment costs alone for non-serious exposures.

We must also consider the costs of a serious exposure. One HIV seroconversion claim can go as high as $500,000. This does not include moneys spent on increased self insured retention, replacement of the lost worker, possible OSHA fines, liability insurance cost increases, legal fees, public relations costs and recruitment costs. The tragedy is that all of this could have been prevented had the health care worker had access to effective, safe needle products.

Although H.R. 1304 focuses on the development of safer needles in the health care setting, ASMT urges that assessment standards for other hazardous medical devices in the clinical laboratory also be developed in order to ensure the safety of both the health care worker and the patient. Areas of attention must include specimen tubes, glass pipettes, vacuum tubes, and capillary tubes. Each of these devices plays an integral role in laboratory testing and holds safety risks for the clinical laboratory professional.

ASMT wants to thank Representative Pete Stark for introducing H.R. 1304, legislation that can improve the environment that many health care workers perform in daily. ASMT also wants to thank you Chairman Rangel for cosponsoring this legislation and for holding this insightful hearing today. Thank you for the opportunity to appear before the Subcommittee this afternoon.

Mr. MCNULTY. Next we will hear from Linda Chiarello, who is the AIDS Program Manager at the New York State Department of Health.

Welcome and please give my best regards to Mark Chassin, New York State health commissioner, when you get home.

STATEMENT OF LINDA CHIARELLO, AIDS PROGRAM MANAGER, NEW YORK STATE DEPARTMENT OF HEALTH, AIDS INSTITUTE, ALBANY, N.Y., ON BEHALF OF THE ASSOCIATION FOR PRACTITIONERS IN INFECTION CONTROL, INC.

Ms. CHIARELLO. Thank you.

Mr. Chairman and distinguished subcommittee members, thank you for the opportunity to speak here today. My name is Linda Chiarello. I am a certified infection control practitioner employed by the New York State Department of Health, AIDS Institute. I also had the privilege of coordinating New York State's 10-hospital study of needlestick prevention devices. However, I am here today on behalf of the Association for Practitioners in Infection Control to provide testimony on a proposal to impose a 3-year tax on needle devices the FDA determines to be unsafe.

Because this proposal has been included in a hearing on tax issues affecting the health and safety of inner-city residents, there is an implicit message of intent to stimulate the production and consumption of needles and syringes that cannot be reused with the hope of limiting access by illicit IV drug users. APIC has previously addressed the issues reflected in H.R. 1304. The focus of my remarks will therefore be on the distinction between safer devices for health care worker protection and safer devices for purposes of harm reduction to protect inner cities. I hope to dispel any perceptions that the two are synonymous, or that taxing existing needles and syringes is a solution to protecting inner cities.

The plight of our inner-city residents is a national concern that deserves thoughtful attention to solutions that will improve the health and social environment of this population. Because the use of illicit drugs is strongly associated with poverty, crime and disease transmission, strategies to improve the health and safety of our inner cities must focus on modifying drug use behavior and controlling its impact through harm—reduction strategies. Harm reduction is a term used to define strategies which may fall short of achieving the prevention goal, but provide safer alternatives which may be more realistic and acceptable to an individual who is not motivated to change.

In the area of illicit IV drug use, harm reduction approaches include education about needle-sharing and disinfection of works, legal purchase and/or needle exchange programs. An element of the proposal before you is yet, in some ways, another harm-reduction approach which is intended to increase assurance that a needle or syringe, once used, cannot be subsequently reused. While this is not likely to eliminate illicit drug use, the concept has merit, if it can be integrated into broader strategies for development of safer devices.

Within this country, the production of needles and syringes meets the need for this equipment in health care, veterinary medicine, the pharmaceutical industry, and by the scientific community.

Similar devices, which come in many sizes, can be sold for distribution to multiple users. Those that have been typically acquired for illicit injection purposes are limited to the smaller insulin and tuberculin syringes.

Needles and syringes are approved by the FDA as safe when they demonstrate that they conform to certain specifications. The safety criteria applies to intended performance for patient care, not for any subsequent use or misuse.

In the health care setting, safe needles for patient care, once contaminated, have been associated with transmission of over 20 pathogens to persons providing patient care or engaged in laboratory testing. The HIV epidemic has drawn attention to these risks and has spurred promotion of safer technology to reduce this hazard to health care workers.

As this technology has evolved, it has become clear that evaluation in clinical settings is essential. Many devices which appear to offer both patient and health care worker protection have not been as successful as anticipated in the hands of clinical users. Several devices have been invented with the intention of rendering needles and syringes inoperable after a single use. Only one has progressed to any level of production, and this device is not available in the United States.

There has been little or no clinical evaluation of other devices to determine how well they work in patient care. In addition, strategies to render a device inoperable after a single use may not adequately address issues of safer technology for health care workers.

It is important to appreciate that some procedures require that a needle or syringe be used for more than one injection on the same patient, which could conflict with strategies proposed for harm reduction. Also, for purposes of cost control, many diabetics routinely use one needle or syringe for multiple injections during a single day or over several days without adverse consequences. A device designed to be rendered inoperable after a single use would infringe on this aspect of patient care.

Another important consideration in the proposed tax is that it is likely to be passed on to the consumer. And patients frequently pay for syringes out of pocket. Typically, this amounts to 17 to 22 cents per syringe; and a diabetic, for example, may require one to four injections per day.

The incremental cost of safer technology to protect health care workers is between two and five times and sometimes more than that of existing equipment. Any tax would have to exceed the incremental cost of the desired replacement to provide purchase motivation. The potential impact on the population already beset with burdensome direct health care costs is obvious.

APIC has actively promoted the development and implementation of safer technology, while recognizing the importance of applying scientific principles in research and epidemiology to establish priorities and balance the interests of patient care and health care worker protection. We believe the consideration of a tax on needles and syringes is premature and unrealistic, given the status of the technology, and would inappropriately penalize individuals who have no alternative choice.

It is likely that there will always be a need for needle devices, despite advances in technology. Ultimately devices used for injection should combine design strategies to prevent injury by a contaminated needle, as well as inappropriate secondary use. The state of the art is not widely available and will require clinical evaluation as it does emerge.

Thank you for your attention.

[The prepared statement follows:]

House Subcommittee on Select Revenue Measures

Committee on Ways and Means

Tax Issues Affecting the Health and Safety of Inner-City Residents

and Other Miscellaneous Health-Related Tax Issues

Testimony of The Association for Practitioners in Infection Control, Inc.

June 29, 1993

Mr. Chairman and distinguished subcommittee members, thank you for the opportunity to speak to you today. My name is Linda Chiarello; I am a registered nurse and certified infection control practitioner in the New York State Department of Health. I am here today on behalf of the Association for Practitioners in Infection Control (APIC) to provide testimony on a proposal before you to impose a three year tax on needle devices the Food and Drug Administration determines to be unsafe. Implicit in this proposal, from the perspective of protecting inner cities, is an intent to stimulate the production and consumptions of needles/syringes that cannot be reused with the hope of limiting access to devices by illicit drug users in the community.

APIC speaks to this issue as a national organization of nearly 10,000 members who have primary responsibility for the prevention and control of infections acquired in a variety of health care settings. As part of its mission, APIC seeks to inform decision-makers at all levels in the public and private sectors on issues relevant to its role in health care. In this regard, the membership promotes solutions to infection control problems affecting the public health that are scientifically supported and appropriately represent the concerns of the health care community in its broadest sense.

The focus of my remarks will be on the availability of the technology to accomplish the desired objective, its potential conflict with patient care and health care worker protection, and potential implications of imposing a tax on existing technology. As with so many aspects of health care, the obvious solutions are not as easy as they first appear.

The plight of inner-city residents is a national concern that deserves and requires thoughtful attention to solutions that will improve the health and social environment of this population. Because the use of illicit drugs self-administered by injection is strongly associated with poverty, crime, and disease transmission, particularly HIV, strategies to improve the health and safety of our inner-cities must focus on modifying drug-use behavior and controlling its impact through harm reduction strategies.

Harm reduction is a term used to define strategies which may fall short of achieving the optimum prevention goal (i.e., eliminate intravenous drug use) but provide safer alternatives which may be more realistic and acceptable to an individual who is not motivated to change. In the area of illicit intravenous drug use, harm reduction approaches include educating current drug users not to share needles, syringes, and "works" and to disinfect with bleach equipment that is shared or purchased on the street. In this country, harm reduction through needle exchange programs is a relatively new and controversial approach. However, it has had a demonstrated benefit in limiting needle sharing and removing used needles from the city streets. It is too early to conclude that it has had an impact on disease transmission but at least in some programs there has been stabilization of transmission rates.

The proposal before you is yet another harm reduction approach which is intended to increase assurances that a needle/syringe once used, cannot be subsequently reused. While this is not likely to eliminate illicit drug use, even use by injection with traditional needles, the concept has merit if it can be integrated into broader strategies for development of safer devices.

However, consideration of such an approach must be viewed within the context of its

broader impact. Questions that must be asked include: "Is there a proven technology available?", "What will be its impact on the broader public?", "What will it cost" and "Who will bear the cost?".

Within this country, the production and distribution of needles and syringes is a billion dollar industry which meets the need for this equipment in health care, veterinary medicine, the pharmaceutical industry, and by the scientific community. Because of similar functional needs, similar devices, which come in many sizes, can be sold for distribution to multiple users. Those that have typically been acquired for illicit injection purposes are limited to the smaller insulin and tuberculin syringes.

Needles and syringes are approved by the FDA as safe for health care when they demonstrate that they conform to certain specifications. The safety criteria apply to intended performance for patient care, not for any subsequent use or misuse. The use of the term "unsafe needle" must, therefore, be considered in the context of what is meant by "safety". These devices pose a danger to another individual when they become blood contaminated and there is opportunity for injury or secondary use. A broad segment of needles, such as those used in the pharmaceutical industry, pose no immediate harm.

In the health care setting, contaminated needles have been associated with transmission of over 20 pathogens to persons providing patient care or engaged in laboratory testing. The HIV epidemic has drawn attention to these risks and has spurred promotion of safer technology to reduce this hazard to health-care workers. Devices such as needleless systems and recessed needles for intravenous delivery, self-shielding needles, and user-activated needle guards on syringes are but some of the approaches currently being evaluated for practicality, acceptability, and cost-effectiveness. As this technology has been evolving, it has become clear that the evaluation of these devices in clinical settings is essential for determining their acceptability for patient care as well as worker protection. Many devices which have appeared to offer both benefits have not been successful in the hands of clinical users. However, as the technology improves, these devices are gradually being implemented in various health care settings.

The issue of secondary needle/syringe use concerns factors associated with the acquisition of such devices by illicit injecting drug users. Individuals involved in programs that work with current or recovering intravenous drug users report that sterile injection equipment is often obtained by diverting or stealing supplies from legitimate medical sources. Other supply sources, inadvertent or intentional, may be home users of needles and syringes. Although the purchase of syringes, for example, is controlled by prescription, in most communities there is no control over home disposal and these implements readily find their way into the community waste stream. While the majority of home users destroy their implements before disposal, and usually place them in rigid containers, some remain intact and can be picked up for reuse. The development of a technology which prevents secondary reuse of needles/syringes would, therefore, address only the issue of needle sharing, and not injecting drug use per se.

Several devices have been invented with the intention of rendering needles and syringes inoperable after a single use; only one has progressed to any level of production. However, this device is not available in the United States due to the absence of a market demand for the product. There has been little or no clinical evaluation of these devices to determine how well they work in patient care. In addition, strategies to render a device inoperable after a single use may not adequately address issues of safer technology for health-care workers. Indeed, the design of one device I have personally examined which is being actively promoted by the inventor, effectively eliminated that opportunity to reuse the syringe but does nothing to protect the needle. Another strategy has the capability of promoting touch contamination which poses a concern for patient protection.

It is important to appreciate that some procedures require that a needle/syringe be used for more than one injection on the same patient, which could conflict with strategies proposed for harm reduction . One example is in the administration of local anesthetic. Also, for purposes of cost control, many diabetics routinely use one needle/syringe for multiple injections during a single day or over several days without adverse consequence. A device which was

designed to be rendered inoperable after a single use would infringe on this aspect of patient care.

Another important aspect of the proposal to tax "unsafe" needles and syringes concerns cost. Any tax imposed is likely to be passed on to the consumer, whether it be the large industries of users mentioned above or individuals in the home. In either case it is an unfair burden for primary users. From the perspective of how such a tax might impact home users of needles/syringes, currently, Medicare, Medicaid, and other third party payors cover the cost of prescribed drugs (e.g., insulin), but patients frequently pay for syringes out-of-pocket. Typically this amounts to $.17-.22 per syringe and a diabetic, for example, may require 1-4 injections per day. The incremental cost of safer technology targeted to protect health-care workers is between two and five times that of existing equipment. Any tax would have to exceed the incremental cost of the desired replacement to provide purchase motivation. The potential impact on a population already beset with burdensome direct health care costs is obvious.

APIC has been active in promoting the development and implementation of safer technology while recognizing the importance of applying scientific principles in research and epidemiology to establish priorities and balance the interests of patient care and health care worker protection. We believe the consideration of a tax on needles/syringes is premature and unrealistic, given the status of the technology, and would inappropriately penalize individuals who have no alternative choice. We recommend that alternative solutions to a tax be explored. Such solutions must first assure that the legitimate use of needles and syringes by the health care industry is not compromised while also supporting ongoing efforts to adopt safer technology for health-care worker protection. Strategies for consideration, which focus less on technology and more on access, include establishment of local collection points for used syringes and mailing options, a practice currently used by some private health care offices. APIC recognizes that harm reduction alternatives have the potential for limiting disease transmission in the inner cities and supports scientific research in this area.

It is likely that there will always be a need for needled devices, despite advances in technology. Ultimately, devices used for injection should combine design strategies to prevent injury by a contaminated needle as well as inappropriate secondary use. The state-of-the art is not widely available and will require clinical evaluation as it does emerge. This too needs to be actively supported on a national basis.

Thank you for your attention.

Mr. MCNULTY. Thank you. It raises a lot of interesting questions.

I am particularly interested in your testimony about individuals who use a needle repeatedly, and I am not so sure that I agree with your conclusion. We have so much evidence that AIDS is spread by the use of contaminated needles. I know there is a trade-off here, but it would seem to me that you would be asking yourself, is it worth the price in these limited instances that you pointed out for that person or society, in the form of universal health care, whatever, to pay that extra few cents a needle for their use in order to protect the overall society from the increased spread of AIDS, which is an enormous cost to everyone?

And my initial reaction is that I would come down on the other side of that.

Ms. CHIARELLO. And I can certainly appreciate that, Mr. Chairman.

I think—this is not a very simple issue. It happens to be very complex. The risk of HIV transmission is really through sharing needles and not through a single individual reusing it for their own purpose. And giving local anesthesia, for example, during—infiltrating a wound or in the dental setting, typically that same needle is used on one patient. They are not shared among patients. And diabetics do reuse their syringes.

I have had an opportunity to look at several of the devices that are emerging as single-use syringes. One of them, in fact, does nothing to protect health care workers. It eliminates the syringe from being reused in some ways, although I think it has a ratchet device that could be altered by intent by an individual; but it does nothing to protect the needle. So health care workers who were using a single-use syringe may still be at risk for needlestick injury because the device was intended to prevent secondary illicit use.

So the point I am trying to make is that in evaluating all of these strategies, either for harm reduction or protection of health care workers, we have to merge the technology in some way to make sure both objectives are being met.

The second point is that I think we need more study to determine that indeed the reuse of needles or eliminating reuse of needles by modification of the equipment for the IV-drug-using community is a solution. And Congressman Wyden has directed the OTA to develop a report on single-use equipment which should be out very—fairly soon. And that has some very telling information in it on this issue.

Mr. MCNULTY. Well, I agree that we ought to look at all the available information. And I think we should be able to come up with the technology to provide the protection that you are seeking for health care workers.

But I do think in the end we have to make this judgment about a modest increase in cost, perhaps, for some small segment of the population versus the enormous cost in terms of the provision of health care and the enormous cost to families as a result of death of individuals from this disease; and that that ought to be a very strong determining factor in how we move on this.

But I thank you for your testimony.

Incidentally are there any economic studies that support your assertion that an excise tax on unsafe needles would not be effective

unless it was equal to the incremental cost of the safer alternatives? Do you have any studies on that?

Ms. CHIARELLO. No, I don't have studies on that. I have the information on the incremental cost of the safer technology for health care worker protection. And one needle device, for instance, is an 1,800 percent increase over the existing cost of needles. So a 10-cent tax increase on existing needles would not be a deterrent to their purchase, given the cost of some of the other technologies. So that was the point I was trying to make.

Mr. MCNULTY. Thank you.

Ms. Berzin, you pointed out in your testimony that H.R. 1304 would require the Food and Drug Administration to develop performance safety standards for needle-bearing devices within 1 year of enactment. Given the great threat posed to health care workers and others by such devices, why in your opinion has the FDA not already done so?

Ms. BERZIN. Possibly with a new administration we will see it.

Mr. MCNULTY. But why not up until now?

Ms. BERZIN. It apparently wasn't felt to be important enough.

Mr. MCNULTY. Well, I hope that the testimony that we are hearing today will convince some people of the importance of the issue.

Ms. Luebbert, as you know, H.R. 1304 would impose a 10-cents-per-needle excise tax on devices that failed to meet FDA standards. In your opinion, would this level of tax be sufficient to deter hospitals from purchasing unsafe needles?

Ms. LUEBBERT. The level of tax of 10 cents, as my colleague noted, would be a minimal addition to the cost of some of the health devices we have right now. When I look at purchasing equipment, let's say something costs a dollar normally, and we can see it go up to $2 or $3 at this point, to add the safety addition to the piece of equipment. And it can go even higher depending upon the complexity of the equipment.

Mr. MCNULTY. On behalf of Chairman Rangel, I want to thank all of you for your testimony.

I would ask Congressman Hoagland if he would have any questions.

Mr. HOAGLAND. Peggy, I don't think any of you have described an unsafe needle and a safe needle for us. Would you take a stab at that?

Ms. LUEBBERT. The difference between the two? Well, from the laboratory's point of view, right now there is equipment available that, once you draw the blood, then you have a resheathing device that comes up over the needle. And those pieces of equipment are what would be considered, right now, first generation and the safest available. So they are either a—at this point, a resheath, resheathing device, or a mechanism where the needle has been replaced with a blunt end that is not considered sharp and couldn't break skin.

Mr. HOAGLAND. And do most nurses at your hospital just carry around the sharp needles when they have completed using them?

Ms. LUEBBERT. Well, at this point, under the blood-borne pathogen standard for OSHA, if you are working with sharps, you are required to have an appropriate needle box available at the point

of use. And those boxes are to be in the rooms. You will see in most acute-care patient rooms now those boxes available.

Most of the sticks, however, occur between the actual procedure and getting the needle to the box—that we are seeing now, since we have the boxes available. So it is when you are working with the uncooperative patient, or something occurs where it is in the handling of it.

So what we are requesting is that the equipment be made safe right at the point of use.

Mr. HOAGLAND. By a resheathing device of some sort?

Ms. LUEBBERT. Or eliminating the sharp itself.

Mr. HOAGLAND. Now, why aren't the hospitals willing to do that now?

Ms. LUEBBERT. Well, at this point it is—a lot of it is money, we are looking at an increase in costs; and also confusion over what is safe and what is unsafe. And that is part of my testimony, is that what I would like to see to make my life easier, and from a purchasing point of view, some kind of standard set so that I would know when a piece of equipment comes into the facility that it has been either approved by someone or meets the standards. And that way I have something to go by when I am purchasing.

Mr. HOAGLAND. So you would support that aspect of H.R. 1304 that requires the FDA to establish assessment guidelines?

Ms. LUEBBERT. Yes, yes. I would like to have health care workers' input into that as well as some of the groups that have done some studies into it, yes.

Mr. HOAGLAND. And it is your sense that the hospitals are sufficiently insensitive to this issue that it is necessary for Congress to pass a law designed to——

Ms. LUEBBERT. Well, I have seen and worked with both. I, in the last year, have probably done about 50 workshops throughout the United States on helping hospitals deal with the OSHA, bloodborne pathogen standard; and I have to say that some hospitals have been very progressive, including my own, in, as long as you can show justification for the use of it and the safe practice associated with it, that some have incorporated them—those into their facilities. But there have been many who have not.

Mr. HOAGLAND. Now, you know, generally we have taken the approach here of granting discretion to OSHA administrators and then asking them to take whatever measures necessary to make the workplace safer. Would that be a better approach, do you think, than legislating on a specific issue like this?

I mean, there are probably lots of other similar specific issues, aren't there, in a hospital?

Ms. LUEBBERT. OSHA does if standards are in place. For example, OSHA, for all their standards, requires for the protection of the employee a threefold process. They first look at engineering controls; then, if you cannot protect the employee through engineering controls—and that is what safe needles would be—then you fall back on safe work practice and personal protective equipment.

And at this point, the only protective equipment available for needles would be steel gloves. And so what we fall back on right now is safe work practices.

Mr. HOAGLAND. And if these assessment guidelines were enacted, would OSHA then enforce them?

Ms. LUEBBERT. Right, once OSHA has standards; and they have shown that in their past standards, their own standards, that if they have standards for guidelines, they will recommend that you fall back on these. Right now, they are just telling us to use safe needles, to use safe equipment, but have not given us guidelines on what is safe. If standards were available, I think it would be more apt that OSHA would put them into their protocols.

Mr. HOAGLAND. Good, thank you.

Thank you, Mr. Chairman.

Mr. MCNULTY. Thank you, Congressman Hoagland.

I want to also welcome Congressman Hancock and Congressman Kopetski, who have joined us. I would like to ask unanimous consent on the part of our colleague, Congressman Stark, to submit some written questions to Secretary Shalala of the Department of Health and Human Services for her later response. Is there objection to that request?

[The information follows:]

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON SELECT REVENUE MEASURES

July 12, 1993

The Honorable Donna E. Shalala
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Shalala:

The Subcommittee on Select Revenue Measures of the Committee on Ways and Means conducted a hearing on Tuesday, June 29, 1993, on tax issues affecting the health and safety of residents of inner-city and other distressed communities. Among the proposals considered was H.R. 1304, a bill to impose an excise tax on certain unsafe needles, which was introduced by Representative Pete Stark (D., CA.) and myself.

I am writing to solicit the Department's views on this legislation because, under the bill, the Food and Drug Administration would be required to prescribe the safety standards for these needles. I would appreciate it if the Department could submit its views in a written statement to be inserted in the record of the hearing by July 26, 1993.

I appreciate your cooperation and look forward to working with you on this legislation.

Sincerely yours,

Charles B. Rangel
Chairman

CBR:jfb

"SEC. 4491. IMPOSITION OF TAX.

"(a) GENERAL RULE.—There is hereby imposed on the taxable sale of any taxable medical item a tax of 10 cents per item.

"(b) TERMINATION.—No tax shall be imposed by this section on any sale after December 31, 1999.

"SEC. 4492. DEFINITIONS AND SPECIAL RULES.

"(a) TAXABLE MEDICAL ITEM.—For purposes of this subchapter—

"(1) IN GENERAL.—The term 'taxable medical item' means any item—

"(A) which is—

"(i) a syringe, or

"(ii) an item which is designed to be part of an intravenous system and to which a standard prescribed under paragraph (2) applies,

"(B) which is manufactured or produced in the United States or entered into the United States for consumption, use, or warehousing, and

"(C) which does not meet the applicable standard prescribed under paragraph (2).

"(2) ANTINEEDLESTICK PREVENTION STANDARDS.—Not later than the date 1 year after the date of the enactment of this section, the Commissioner

of the Food and Drug Administration shall prescribe safety performance standards for syringes, and such components of intravenous systems as such Commissioner deems appropriate, for purposes of preventing accidental needlestick injuries to health care providers. Not less frequently than annually, such Commissioner shall review such standards and make such revisions as such Commissioner may deem appropriate. Before prescribing any such standards or making any revisions of such standards, such Commissioner shall consult with appropriate private sector experts.

"(3) EXEMPTIONS.—The Commissioner of the Food and Drug Administration may by regulation provide for such exemptions from the tax imposed by section 4491 as such Commissioner may deem appropriate.

"(b) TAXABLE SALE.—For purposes of this subchapter—

"(1) IN GENERAL.—The term 'taxable sale' means any sale of a taxable medical item to a health care provider for use in the United States in providing health care services, but only if such sale is the first sale to such a provider for such use after manufacture, production, or importation.

"(2) HEALTH CARE PROVIDER.—The term 'health care provider' means any person or entity (including a governmental entity) which provides services covered under the insurance program established by title XVIII of the Social Security Act and which has a provider number issued pursuant to such program.

"(c) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this subchapter—

"(1) UNITED STATES.—The term 'United States' has the meaning given such term by section 4612(a)(4).

"(2) DISPOSITION OF REVENUES FROM PUERTO RICO AND THE VIRGIN ISLANDS.—The provisions of subsections (a)(3) and (b)(3) of section 7652 shall not apply to the tax imposed by section 4491."

(b) The table of subchapters for chapter 36 of such Code is amended by inserting after the item relating to subchapter D the following new item:

"SUBCHAPTER E. Certain medical items."

(c) The amendments made by this section shall apply to sales after December 31, 1996.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 2 8 1994

The Honorable Charles B. Rangel
Chairman, Subcommittee on Select
Revenue Measures
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This is in response to your request for the Department's views on H.R. 1304, a bill to impose an excise tax on unsafe needles.

H.R. 1304 would require the Food and Drug Administration (FDA) to develop, within one year after enactment, "safety performance standards" for syringes and intravenous (IV) systems to prevent accidental needlestick injuries. FDA would be required to review these standards annually. Syringes that did not meet the standards would be subject to a tax of 10 cents per item.

The Administration supports the intent of the legislation to reduce the risk to health care workers from accidental needlestick injuries. Needlestick injuries represent the main occupational risk for health care worker exposure to such pathogens as Hepatitis B virus, Hepatitis C virus, and HIV. However, we oppose H.R. 1304 because, for the reasons stated below, we do not believe that the specific requirements of the bill are needed at this time.

Device manufacturers have substantial incentives to produce the safest possible products, including the need to avoid liability and to retain customer confidence and satisfaction. In recent years manufacturers' voluntary efforts have led to the incorporation of new safety features in needle-bearing devices, and these technological innovations continue. For example, systems without needles or with recessed needles have been developed to replace exposed needles used to connect IV lines. Some syringes used to penetrate the skin have resheathing apparatuses added to them. FDA has approved over 90 medical devices designed to prevent occupational exposure to bloodborne pathogens.

More post-market research is needed to determine how effective anti-needlestick devices are in reducing the rates of needlestick injury. CDC is currently sponsoring studies to evaluate the role of some of these new devices in reducing injuries in medical and surgical settings. Until these data are available, it would be premature to require hospitals to use such devices.

In addition to increasing the safety of the devices themselves, the Federal Government has undertaken initiatives on a number of

other fronts (including user education and training, work practice controls, and other safety features) to reduce the risks to health care workers from accidental needle sticks. In August 1992, FDA, the Centers for Disease Control and Prevention (CDC), and the Occupational Safety and Health Administration (OSHA) sponsored a conference on the prevention of device-mediated bloodborne infections. Since 1992 OSHA has had in effect a standard requiring health care employers to implement administrative, engineering and work practice controls as a primary means of eliminating occupational exposure to bloodborne pathogens. The OSHA standard covers procedures, training, and layout of the workplace, in addition to the safety features of the device itself. The existence of this standard, which is more comprehensive than the provisions of H.R. 1304, is part of the basis for our conclusion that this bill is not necessary at this time.

FDA is currently preparing guidance to assist manufacturers in submitting premarket notifications for devices that incorporate risk reduction technology; FDA will be obtaining public comments on this document at a meeting in May 1994. FDA is also examining ways to provide appropriate incentives for manufacturers to include information on risk reduction features in product labeling. Finally, FDA is encouraging development and adoption, by the health care sector, of voluntary standards to minimize the exposure to bloodborne pathogens.

We believe that effective risk reduction will be realized through coordinated actions on a number of fronts, including user education and training, increased use of products that incorporate risk reduction features, minimizing the use of unprotected needles where possible, and compliance with OSHA's bloodborne pathogen standards. Federal legislation is not needed to provide the impetus for these actions, which are already well under way.

For the reasons stated above, we would oppose H.R. 1304. However, we appreciate your interest in this issue and would be pleased to work with you and to consider your ideas for additional measures to reduce the exposure to bloodborne pathogens in the workplace.

The Office of Management and Budget has advised that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

/s/ Donna E. Shalala

Donna E. Shalala

Mr. McNULTY. And also I am very interested in this testimony about the needles, and as a matter of fact, I have a constituent up our way who has been working on a needle that cannot be reused.

And I would like to ask unanimous consent to submit some testimony on his behalf, as well, or as part of the record of this hearing. Is there objection?

Hearing none, it is so ordered.

[The information follows:]

STATEMENT SUBMITTED FOR THE RECORD
BY ANTHONY J. VALLELUNGA
SUBCOMMITTEE ON SELECT REVENUE MEASURES
HOUSE WAYS AND MEANS COMMITTEE

Over 800,000 needlestick injuries occur in the United States each year. A needlestick is the inadvertent penetration of a healthcare worker's skin by a hypodermic needle.

Such incidents frequently result in exposure to bloodborne pathogens, such as hepatitis B virus (HBV) and human immunodeficiency virus (HIV). Prevention of occupational exposure, especially through needlestick injuries, should therefore be an important public health priority.

I have developed, and have been issued a patent for, a One Time Use Syringe. Designed to fit into a shield and then "lock", this should not to be confused with the current disposable syringe. My design eliminates the possibility that the syringe will be refilled. It can only be used once.

In addition, I also have a patent pending for another syringe I have designed. Known as a "dual" action syringe, one of its features is that it would be non-refillable. In

addition, a mechanism is incorporated that would permit the user to pull the syringe into a shield. Out of harms way, the needle itself will be secured at the rear, reducing possible needlesticks.

The challenge is creating a non-reusable product with three prevention goals: The first is to insure safe patient care. The second is to allow health care workers to proceed with their regular duties without the threat of an inadvertent injury by a contaminated needle. The third is to prevent the unintended secondary use of needles in the community. Unless access to these devices accompanies any technical change to prevent secondary use, the intended benefit may not be achieved.

While the One Time Use Needle will greatly reduce the spread of AIDS and other infectious diseases normally associate with sharing needles, the "dual" action syringe could achieve all these desired objectives, including reduction or elimination of needlesticks.

Ultimately, I am interested in assuring that our public health policies and initiatives are scientifically sound and reflect careful analysis.

Mr. McNULTY. With that, I want to again thank all of the panel members on behalf of Chairman Rangel, and we will now move to Panels 5 and 6, which will be chaired by Congressman Kopetski.

Mr. KOPETSKI [presiding]. We welcome Panel 5, which includes the Coalition to Stop Gun Violence, Michael K. Beard, president and executive director; from the Schwab Rehabilitation Hospital and Care Network in Chicago, Kathleen Yosko is president and chief executive officer; from the National Association for the Self-Employed, Bennie Thayer, chairman and CEO; and finally, from the National Rifle Association, Richard Gardiner, legislative counsel.

We will begin with Mr. Beard.

STATEMENT OF MICHAEL K. BEARD, PRESIDENT, COALITION TO STOP GUN VIOLENCE

Mr. BEARD. Thank you very much, Mr. Chairman. I am Mike Beard, president of the Coalition to Stop Gun Violence; and on behalf of the 37 national organizations that comprise our coalition and our 70,000 individual members nationwide, I would like to thank the committee for this opportunity to testify.

The most glaring problem with the current Pittman-Robertson program is the use of the handgun tax to promote sports shooting. When one considers the damage caused by handgun violence in America, the last item on which a handgun tax should be appropriated is this type of program, which, in fact, acts as a subsidy to the firearms industry by promoting the use of its products.

Pittman-Robertson is the product of another era, another America. In the 1930s, roughly half the population lived in rural areas. Today, more than three-quarters of us live in urban environments, some of which have been made virtually uninhabitable due to the level of violence. Certainly we can find a better way to appropriate the money generated by a handgun tax than we are currently doing.

The number of handguns in the United States has more than doubled since 1970. The murder rate has increased by more than 60 percent. And as gun violence has escalated, so too has the public's demand that the Congress take appropriate measures to restrict the availability of handguns.

Earlier this month the Joyce Foundation released the results of a public survey conducted by pollster Lou Harris. Of the nine gun proposals tested, eight of them received majority support and the ninth was a dead heat. By a 62 to 34 percent majority, Americans supported, quote, "a tax on guns such as on cigarettes," unquote. Banning the sale and ownership of handguns, except for those given permission by a court of law, received 52 to 43 percent support.

To reduce violence and offer relief to inner-city residents and others who are forced to live among unimaginable violence, the coalition supports measures which would reduce the availability of handguns, including raising the tax on handguns to pay for the medical costs associated with handgun violence. We believe that the tax should be raised to a level that will significantly offset gun-related medical costs. We view any reduction in purchases caused by an increase in the price of the tax as an added benefit, which

would itself lessen the number of gun violence victims, and therefore, in turn, reduce the cost to taxpayers of treating those victims.

Removing the handgun tax from the Pittman-Robertson program and placing it in a more appropriate health care trust fund should be a priority of this committee, a change that was recommended by President Reagan's Task Force on Victims of Crime over a decade ago. In this time of deficit reduction, it is outrageous that a program which is little more than a subsidy to the firearms industry should be allowed to continue as it is.

The results of our fascination with handguns and the coddling of the gun industry are disturbing. The level of violence in this country, along with the well-publicized murder of several foreign tourists, have led several European countries to issue travel advisories to tourists heading to American cities.

Many Americans don't have the luxury of being able to heed these warnings, and instead they are forced to live in the neighborhoods that foreign governments are warning their citizens not to visit. As a result, an African-American man living in Harlem will have a lower life expectancy than a man in Bangladesh, one of the poorest countries in the entire world.

Even though the firearms industry benefits from the Pittman-Robertson program, many of its manufacturers circumvent the tax, and it was illustrated by the Wall Street Journal just last year.

To prevent manufacturers from circumventing the tax, the Coalition supports raising additional revenue by extending the handgun tax to include all transfers of firearms. Such a tax would raise more revenue and at the same time reduce sales.

The need to fund hospitals and other health care providers is great. The cost to the health care system of treating gun violence victims has been estimated at $23 billion a year, much paid by taxpayers. We were concerned also about the number of trauma centers that have closed over the last 7 years. The American Medical Association reported that 92 centers have closed between 1987 and 1991, primarily due to uncompensated care given to gun victims. The most obvious consequence of these closings is that adequate trauma care is no longer available to many Americans when they need it, not just to those who suffer bullet wounds, but to all trauma victims.

In 1937, we were a Nation of hunters. Today, many of us feel as if we are the hunted. I am asking this committee to give relief to those who need it, not the hunters and the firearms industry, but the victims of gun violence and the health care providers who treat those victims. Raise the tax on handguns and put that revenue to good use.

Thank you very much.

Mr. KOPETSKI. Thank you, Mr. Beard; and we appreciate your sticking with the 5-minute rule.

[The prepared statement follows:]

STATEMENT OF MICHAEL K. BEARD, PRESIDENT, COALITION TO STOP GUN VIOLENCE

ON BEHALF OF THE 37 NATIONAL ORGANIZATIONS WHICH COMPRISE THE COALITION TO STOP GUN VIOLENCE AND OUR 70,000 MEMBERS NATIONWIDE, I WANT TO THANK CHAIRMAN RANGEL FOR ALLOWING US THIS OPPORTUNITY TO TESTIFY HERE THIS AFTERNOON.

WHILE THE TOPICS DISCUSSED AT THIS HEARING ARE WIDE RANGING, WE WILL FOCUS ON THE EFFECT OF GUN VIOLENCE ON THE HEALTH CARE SYSTEM AND THE PROPOSALS PUT FORWARD IN CONGRESS, INCLUDING THOSE BY REPRESENTATIVE REYNOLDS, WHICH CALL FOR INCREASING THE TAX ON FIREARMS TO ESTABLISH A FUND TO ALLEVIATE THE COST OF GUN RELATED HEALTH CARE.

AT TIMES MY REMARKS WILL MOVE OUTSIDE THE AREA OF INNER-CITY HEALTH CARE SIMPLY BECAUSE GUN VIOLENCE IS NO LONGER A PROBLEM JUST OF THE INNER-CITIES, BUT ONE WHICH AFFECTS ALL OF AMERICA. AND WHILE MY REMARKS TODAY WILL FOCUS ON THE GUN TAX, I WOULD LIKE TO BE CLEAR THAT OUR ORGANIZATION SUPPORTS A COMPLETE BAN ON THE SALE OF HANDGUNS AND ASSAULT WEAPONS TO PRIVATE INDIVIDUALS WITH ONLY A FEW MINOR EXCEPTIONS.

IN 1937 CONGRESS ENACTED THE PITTMAN ROBERTSON PROGRAM. THE ORIGINAL INTENT OF THE LEGISLATION WAS TO PROMOTE HUNTING AND HUNTER SAFETY. THE PROGRAM WAS ESTABLISHED TO DISBURSE MONEY TO STATES FOR USE IN ACQUIRING PUBLIC LANDS, PRESERVING WILDLIFE, PROMOTING HUNTER SAFETY AND BUILDING AND MAINTAINING TARGET SHOOTING RANGES. THE LAW WAS INTENDED TO APPLY TO LEGITIMATE SPORTS SHOOTING ACTIVITIES. TO FUND THE PROGRAM THE CONGRESS USED THE 11% TAX ON RIFLES, SHOTGUNS AND AMMUNITION WHICH HAD BEEN INSTITUTED SEVERAL YEARS EARLIER FOR THE PURPOSE OF RAISING MONEY FOR GENERAL REVENUE DURING THE DEPRESSION.

THE PROGRAM WAS BROADENED IN THE EARLY 1970s, AT THE REQUEST OF THE NATIONAL RIFLE ASSOCIATION, TO INCLUDE A 10% TAX ON HANDGUNS. THE HANDGUN TAX WAS ADDED TO THE FUND'S REVENUE ALTHOUGH IT WAS DISTRIBUTED TO STATES THROUGH A FORMULA BASED PARTLY ON POPULATION AND NOT ON HUNTING LICENSES.

OVER THE YEARS THE PITTMAN ROBERTSON PROGRAM HAS DISBURSED BILLIONS OF DOLLARS TO THE STATES. AT TIMES THE MONEY HAS BEEN MISSPENT LEADING ENVIRONMENTAL GROUPS TO CRITICIZE ITS ACTIONS. IN 1983 A SPOKESPERSON FOR THE SIERRA CLUB LABELED THE PROGRAM'S MANIPULATION OF THE ENVIRONMENT "INTRINSICALLY WRONG." THE AUDUBON CLUB AND THE FRIENDS OF ANIMALS HAVE ALSO BEEN CRITICAL OF THE PROGRAM.

THE MOST GLARING PROBLEM WITH THE CURRENT PROGRAM IS THE USE OF THE HANDGUN TAX TO PROMOTE SPORTS SHOOTING. WHEN ONE CONSIDERS THE DAMAGE CAUSED BY HANDGUN VIOLENCE IN AMERICA, THE LAST ITEM ON WHICH A HANDGUN TAX SHOULD BE APPROPRIATED IS THIS TYPE OF PROGRAM WHICH, IN FACT, ACTS AS A SUBSIDY TO THE FIREARMS INDUSTRY BY PROMOTING THE USE OF ITS PRODUCTS.

PITTMAN ROBERTSON IS THE PRODUCT OF ANOTHER ERA, ANOTHER AMERICA. IN THE 1930s ROUGHLY HALF THE POPULATION LIVED IN RURAL AREAS. TODAY, MORE THAN THREE-QUARTERS OF US LIVE IN URBAN ENVIRONMENTS SOME OF WHICH HAVE BEEN MADE VIRTUALLY UNINHABITABLE DUE TO THE LEVEL OF VIOLENCE. CERTAINLY WE CAN FIND A BETTER WAY TO APPROPRIATE THE MONEY GENERATED BY A HANDGUN TAX THAN WE ARE CURRENTLY DOING.

UNTIL THE LATE 1960s AMERICA WAS A RELATIVELY NON-VIOLENT PLACE--AT LEAST WHEN COMPARED TO TODAY. IN THAT DECADE AMERICANS BEGAN PURCHASING HANDGUNS AS NEVER BEFORE WITH DISASTROUS RESULTS. THE BUREAU OF ALCOHOL, TOBACCO AND FIREARMS ESTIMATES THE NUMBER OF GUNS IN THE UNITED STATES HAS MORE THAN DOUBLED SINCE 1970. SINCE 1967 THE MURDER RATE HAS INCREASE BY MORE THAN 60% FROM 6.1 TO 9.8 PER HUNDRED THOUSAND.

I WILL LIST ONLY A FEW STATISTICS.

--HANDGUNS WERE USED IN 55% OF ALL MURDERS IN 1991 THE LAST YEAR FOR WHICH STATISTICS ARE AVAILABLE.

--GUNSHOT WOUNDS ARE NOW THE LEADING CAUSE OF DEATH OF MALE TEENAGERS AHEAD OF ALL NATURAL CAUSES COMBINED.

--ALL TOLD HANDGUNS KILL MORE THAN 25,000 AMERICANS EACH YEAR.

--THE COST TO THE HEALTH CARE SYSTEM FROM TREATING VICTIMS OF GUN VIOLENCE IS ESTIMATED AT $23 BILLION A YEAR.

--IN TEXAS AND LOUISIANA THE NUMBER OF GUN DEATHS NOW EXCEEDS THE NUMBER OF TRAFFIC FATALITIES. A TREND THE CENTERS FOR DISEASE CONTROL AND PREVENTION ESTIMATES WILL EXTEND TO THE NATION AS A WHOLE BY NEXT YEAR.

THE SITUATION TODAY IS INTOLERABLE. LAST WEEK IN A THREE DAY PERIOD NINE PEOPLE WERE SHOT TO DEATH IN ONE AREA OF SOUTHEAST WASHINGTON. MORE THAN A DOZEN OTHERS WERE WOUNDED INCLUDING 5 CHILDREN WHO WERE SHOT WHILE SEEKING RELIEF FROM THE SUMMER HEAT BY SWIMMING IN A PUBLIC POOL. ONE TEENAGER WITH AN ASSAULT WEAPON HAS THE POWER TO ROB THOUSANDS OF CHILDREN OF ACTIVITIES WE, AS CHILDREN, TOOK FOR GRANTED. ONE CAN ONLY GUESS THE LONG RANGE CONSEQUENCES SUCH AN EVENT HAS ON INNOCENT LITTLE KIDS WHO BECOME VICTIMS OF RANDOM VIOLENCE. AND THIS IS JUST ONE WEEK IN ONE CITY.

AS GUN VIOLENCE HAS ESCALATED, SO TOO HAS THE PUBLIC'S DEMAND THAT CONGRESS TAKE APPROPRIATE MEASURES TO RESTRICT THE AVAILABILITY OF HANDGUNS. JUST A FEW SHORT YEARS AGO THE PUBLIC SUPPORTED GUN CONTROL MEASURES BUT DID NOT CONSIDER THEM A PRIORITY. THAT HAS CHANGED DRASTICALLY.

EARLIER THIS MONTH THE JOYCE FOUNDATION RELEASED THE RESULTS OF A PUBLIC SURVEY CONDUCTED FOR THE FOUNDATION AND THE HARVARD SCHOOL OF PUBLIC HEALTH BY LOU HARRIS. THE RESULTS WERE

OVERWHELMING. NINE OUT OF TEN AMERICANS FAVORS ENACTMENT OF THE BRADY BILL INCLUDING TWO-THIRDS OF RESPONDENTS WHO IDENTIFIED THEMSELVES AS MEMBERS OF THE NRA. OF THE NINE GUN CONTROL PROPOSALS TESTED, EIGHT RECEIVED MAJORITY SUPPORT AND THE NINTH WAS A DEAD HEAT.

BY A 62%-34% MAJORITY AMERICANS SUPPORT A "SPECIAL TAX ON GUNS, SUCH AS ON CIGARETTES." BANNING THE SALE AND OWNERSHIP OF HANDGUNS EXCEPT FOR THOSE GIVEN PERMISSION BY A COURT OF LAW RECEIVED 52%-43% SUPPORT. THE ONLY PROPOSAL NOT TO GATHER A MAJORITY WAS COMBINING A HANDGUN BAN WITH A GUN BUY BACK AT $200 A GUN.

THE HARRIS POLL ALSO REPORTED THAT FOR THE FIRST TIME SUPPORTING GUN CONTROL WOULD NOT BE A POLITICAL LIABILITY BUT INSTEAD WOULD HAVE A POSITIVE EFFECT ON A CLOSE ELECTION. NOW, AMERICANS WHO SAY THEY WILL VOTE AGAINST A CANDIDATE WHO OPPOSES GUN CONTROL, OUTNUMBER THOSE WHO WILL VOTE AGAINST A CANDIDATE WHO SUPPORTS GUN CONTROL.

TO HELP REDUCE THIS VIOLENCE AND OFFER RELIEF TO INNER-CITY RESIDENTS AND OTHERS WHO ARE FORCED TO LIVE AMONG UNIMAGINABLE VIOLENCE, THE COALITION TO STOP GUN VIOLENCE SUPPORTS MEASURES WHICH WILL REDUCE THE AVAILABILITY OF HANDGUNS INCLUDING RAISING THE TAX ON HANDGUNS TO PAY FOR THE MEDICAL COSTS ASSOCIATED WITH HANDGUN VIOLENCE. WE BELIEVE THE TAX SHOULD BE RAISED TO A LEVEL THAT WILL SIGNIFICANTLY OFFSET GUN RELATED MEDICAL COSTS. WE VIEW ANY REDUCTION IN PURCHASES CAUSED BY AN INCREASE IN THE PRICE OF THE TAX AS AN ADDED BENEFIT WHICH WILL ITSELF LESSEN THE NUMBER OF GUN VIOLENCE VICTIMS AND IN TURN REDUCE THE COST TO THE TAXPAYERS OF TREATING THOSE VICTIMS.

TO THOSE WHO MAINTAIN THAT RAISING THE HANDGUN TAX IS MERELY A WAY TO DISARM THE POOR, WE ARGUE THAT WE HAVE SEEN THE DAMAGE CAUSED BY HANDGUNS IN POOR COMMUNITIES, IN MIDDLE CLASS COMMUNITIES AND IN WEALTHY COMMUNITIES AND ANY MEASURE WHICH MAKES HANDGUNS LESS AVAILABLE BENEFITS ALL AMERICANS.

REMOVING THE HANDGUN TAX FROM THE PITTMAN ROBERTSON PROGRAM AND PLACING IT IN A MORE APPROPRIATE HEALTH CARE TRUST FUND SHOULD BE A PRIORITY OF THIS COMMITTEE. WE WOULD ALSO SUPPORT INCLUDING THE TAX ON RIFLES AND SHOTGUNS IN SUCH A TRUST FUND, HOWEVER, WE VIEW THAT AS SECONDARY TO THE PROPOSED CHANGES IN THE HANDGUN TAX--A CHANGE THAT WAS RECOMMENDED BY PRESIDENT REAGAN'S TASK FORCE ON VICTIMS OF CRIME A DECADE AGO.

AT A TIME WHEN THE FEDERAL GOVERNMENT IS STRUGGLING WITH A DEBT OF OVER $3 TRILLION AND BUDGET DEFICITS RUNNING ANNUALLY IN THE HUNDREDS OF BILLIONS OF DOLLARS IT IS OUTRAGEOUS THAT A PROGRAM WHICH IS LITTLE MORE THAN A SUBSIDY TO THE FIREARMS INDUSTRY SHOULD BE ALLOWED TO CONTINUE AS IT IS.

INSTEAD OF SUBSIDIZING THE GUN INDUSTRY WE SHOULD BE REGULATING IT MUCH MORE CLOSELY. UNDER CURRENT LAW THE FEDERAL

GOVERNMENT DOES ALMOST NOTHING TO REGULATE THE MANUFACTURE, SALE OR TRANSFER OF FIREARMS. FEDERALLY LICENSED GUN DEALERS ARE LOOSELY REGULATED AND ALMOST ANYONE PAYING THE $30 FEE CAN OBTAIN THE THREE YEAR LICENSE. FIREARMS ARE NOT REGULATED FOR SAFETY AND, IN FACT, THE CONSUMER PRODUCT SAFETY COMMISSION IS STATUTORILY FORBIDDEN FROM EXAMINING THEIR SAFETY. IMPORTED GUNS ARE PROHIBITED IF THE BATF DETERMINES THEY DO NOT HAVE A SPORTING PURPOSE, HOWEVER, NO SUCH RESTRICTIONS ARE PLACED ON DOMESTIC MANUFACTURERS--ANOTHER BOON TO THE INDUSTRY. AND UNTIL THE BRADY BILL IS PASSED WE CONTINUE TO ALLOW CONVICTED FELONS TO PURCHASE GUNS ON THE HONER SYSTEM. SIGN A FORM STATING YOU ARE NOT A FELON AND IN MOST STATES YOU CAN WALK OUT WITH THE GUN OF YOUR CHOICE.

THE RESULTS OF OUR FASCINATION WITH HANDGUNS AND CODDLING OF THE GUN INDUSTRY ARE DISTURBING. OUR MURDER RATE IS TEN TIMES THOSE OF EUROPE AND JAPAN WHERE HANDGUNS ARE TIGHTLY RESTRICTED. THE LEVEL OF VIOLENCE IN THIS COUNTRY ALONG WITH THE WELL PUBLICIZED MURDER OF SEVERAL FOREIGN TOURISTS HAVE LED SEVERAL EUROPEAN COUNTRIES TO ISSUE TRAVEL ADVISORIES TO TOURISTS HEADING TO AMERICAN CITIES--THE KIND OF WARNING USUALLY ISSUED TO TRAVELERS HEADING TO DEVELOPING NATIONS WITH UNSTABLE GOVERNMENTS.

MANY AMERICANS DO NOT HAVE THE LUXURY OF BEING ABLE TO HEED THESE WARNINGS. INSTEAD THEY ARE FORCED TO LIVE IN THE NEIGHBORHOODS FOREIGN GOVERNMENTS WARN THEIR CITIZENS TO STAY AWAY FROM. AS A RESULT AFRICAN-AMERICAN MEN LIVING IN HARLEM HAVE A LOWER LIFE EXPECTANCY THAN MEN IN BANGLADESH--ONE OF THE POOREST COUNTRIES ON EARTH.

EVEN THOUGH THE FIREARMS INDUSTRY BENEFITS FROM THE PITTMAN ROBERTSON PROGRAM, SOME MANUFACTURERS CIRCUMVENT THE TAX. LAST YEAR THE WALL STREET JOURNAL PUBLISHED A FRONT PAGE EXPOSE' ON THE LARGEST MAKERS OF SATURDAY NIGHT SPECIAL HANDGUNS IN THE US. SATURDAY NIGHT SPECIALS ARE CHEAP EASY TO CONCEAL HANDGUNS OFTEN USED IN CRIME. SINCE 1968 THEY HAVE BEEN BANNED FROM IMPORTATION BECAUSE THEY LACK ANY SPORTING PURPOSE. IN 1989 PRESIDENT BUSH PLACED THE SAME RESTRICTIONS ON ASSAULT WEAPONS USING THE SAME SPORTING PURPOSE CRITERIA.

THE JOURNAL NOTED THAT BY CONTROLLING BOTH THE MANUFACTURER AND THE DISTRIBUTOR, GUN MAKERS ARE ABLE TO AVOID THE EXCISE TAX:

> ACCORDING TO FEDERAL OFFICIALS FAMILIAR WITH THE IRS PROBE, THE ALLEGED EXCISE SCHEME WAS SIMPLE: THE 10% EXCISE TAX IS LEVIED ONLY ON THE PRICE CHARGED BY THE GUN MAKER, NOT THE WHOLESALER. SO CALWESTCO AND BYRCO ALLEGEDLY SKIRTED THE NORMAL TAX AMOUNT BY CHARGING ARTIFICIALLY LOW PRICES WHEN THEY SOLD THEIR GUNS TO JENNINGS FIREARMS. THEN, JENNINGS FIREARMS IN ITS ROLE AS WHOLESALER BUT NOT GUN MAKER, SHARPLY INCREASED THE PRICE AND RESOLD

THE PISTOLS TO OTHER WHOLESALERS, PAYING NO EXCISE TAX AND REAPING BIG PROFITS.

INCIDENTALLY, SINCE THE JOURNAL ARTICLE RAN, THE LORCIN COMPANY, WHICH WAS ALSO CRITICIZED IN THE ARTICLE HAVE RUN ADVERTISEMENTS FEATURING THAT DAY'S JOURNAL WITH SEVERAL BULLET HOLES IN THE PAPER.

TO PREVENT MANUFACTURES FROM CIRCUMVENTING THE TAX THE COALITION WOULD SUPPORT RAISING ADDITIONAL REVENUE BY EXTENDING THE HANDGUN TAX TO INCLUDE ALL TRANSFERS OF THE WEAPON. SUCH A TAX WOULD RAISE MORE REVENUE AND AT THE SAME TIME REDUCE SALES.

THE NEED TO FUND HOSPITALS AND OTHER HEALTH CARE PROVIDERS IS GREAT. AS I MENTIONED EARLIER THE COST TO THE HEALTH CARE SYSTEM OF TREATING GUN VIOLENCE VICTIMS IS ESTIMATED AT $23 BILLION ANNUALLY. EQUALLY FRIGHTENING IS THE NUMBER OF TRAUMA CENTERS FORCED TO CLOSE OVER THE LAST SEVERAL YEARS DUE TO LOST REVENUE INCURRED BY TREATING UNINSURED GUN SHOT VICTIMS. A STUDY IN SAN FRANCISCO SEVERAL YEARS AGO ESTIMATED THAT 86% OF THE COST OF TREATING GUNSHOT VICTIMS IS BORN DIRECTLY BY THE TAXPAYER. AS YOU ARE AWARE COST SHIFTING ACCOUNTS FOR A GOOD SHARE OF THE REST OF THE COST.

LAST JUNE THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION REPORTED THAT 92 TRAUMA CENTERS AROUND THE NATION CLOSED BETWEEN 1987 AND 1991 PRIMARILY DUE TO UNCOMPENSATED CARE GIVEN TO GUN VIOLENCE VICTIMS. CHICAGO WAS PARTICULARLY HARD HIT WITH 8 OF ITS CENTERS GOING UNDER.

WHAT IS THE SIGNIFICANCE OF THESE CLOSINGS? THE MOST OBVIOUS CONSEQUENCE IS THAT ADEQUATE TRAUMA CARE IS NO LONGER AVAILABLE TO MANY AMERICANS WHEN THEY NEED IT--NOT JUST THOSE WHO SUFFER BULLET WOUNDS BUT ALL TRAUMA VICTIMS. TRAUMA DOCTORS TALK ABOUT A "GOLDEN HOUR" DURING WHICH IF AN INJURY VICTIM IS TREATED PROPERLY, HE OR SHE IS LIKELY TO RECOVER. AS TRAUMA CENTERS ARE FORCED TO SHUT DOWN MORE AND MORE AMERICANS NO LONGER LIVE WITHIN THIS "GOLDEN HOUR" OF THE NEAREST TRAUMA UNIT.

THE UNITED STATES HAS CHANGED DRAMATICALLY SINCE THE PITTMAN ROBERTSON PROGRAM WAS STARTED. SOME CHANGES HAVE BEEN GOOD AND OTHERS HAVE NOT. IN 1937 WE WERE A NATION OF HUNTERS. TODAY, TOO MANY OF US FEEL AS IF WE ARE THE HUNTED. I AM ASKING THIS COMMITTEE TO GIVE RELIEF TO THOSE WHO NEED IT--NOT HUNTERS AND THE FIREARMS INDUSTRY--BUT VICTIMS OF GUN VIOLENCE AND HEALTH CARE PROVIDERS WHO TREAT THESE VICTIMS. RAISE THE TAX ON HANDGUNS AND PUT THE REVENUE TO GOOD USE. THANK YOU.

Mr. KOPETSKI. Ms. Yosko, you are president and CEO of the Schwab Rehabilitation Hospital and Care Network. Welcome.

STATEMENT OF KATHLEEN C. YOSKO, PRESIDENT AND CHIEF EXECUTIVE OFFICER, SCHWAB REHABILITATION HOSPITAL AND CARE NETWORK, CHICAGO, ILL.

Ms. YOSKO. Thank you. Good afternoon. As a member of the board of directors for the leading rehabilitation organizations—the National Association of Rehabilitation Facilities, the Commission on Accreditation of Rehabilitation Facilities, the American Hospital Association Section for Rehabilitation Hospitals and Programs, and the Medical Rehabilitation Education Foundation—I am proud to represent a cost-effective medical service that returns individuals to productive lives within their communities.

But I am not here today formally representing these organizations. Today I am here representing Jonathan Williams, Gina Benevides, Steve Estrada, Andre Moseley, and others who needed rehabilitation services because they had been victimized by gun violence.

Two-year-old Jonathan was snatched from his mother's side and shot through his head as he was held up by an adult, as he was being used as a protective human shield. Gina, 19, was shot in the back while sitting in a parked car talking with her girlfriends. Steve, 24, was shot in the spine after a $9 robbery. And Andre, 28, was paralyzed after being shot in the course of his work as a security guard.

Jonathan, Gina, Steve and Andre, like many other patients whom we have treated, have now returned to school, jobs and families, as a result of effective trauma intervention and comprehensive rehabilitation care. It is on their behalf that Schwab supports title III of H.R. 737 and similar legislation that would provide much—needed assistance to hospitals in order to help cover the cost of providing medical care to gunshot victims.

Schwab is an 85-bed comprehensive physical medicine and rehabilitation hospital located in Chicago. Like most rehabilitation hospitals, our patient population primarily includes persons who have experienced strokes, amputations, congenital and degenerative conditions, and head and spinal cord injuries. Because of the increase in the number of our spinal cord injury patients, primarily due to gun violence, Schwab opened a new 12-bed spinal cord unit just last month.

Schwab is the only rehabilitation hospital affiliated with three of the four adult level 1 trauma centers in Chicago. As a result, we are likely to continue to see more individuals with gunshot injuries over the next year. During a 6-month study period last year, more than 60 percent of patients admitted to Schwab for spinal cord injuries had been victims of violence. The vast majority of these were young people.

Lifetime costs of treating a person with serious spinal cord injury can be from $3 to $5 million. As a rehabilitation hospital where Medicaid and Medicare—in essence, the taxpayers—pay for more than 80 percent of the care that we provide, guns have had a costly effect.

It is important to point out that firearm violence and its costs are not just an inner-city problem. Christ Hospital in the Chicago suburb of Oak Lawn reported that in 1990 they treated only four gunshot wound victims from the suburbs. In 1991, that figure rose to 100 and grew to 140 in 1992. For reasons such as this, the Metropolitan Chicago Healthcare Council has fully supported H.R. 737. The Illinois Hospital Association has supported passage of a similar bill in the State legislature.

Our patients have faces and voices. Beyond the fleeting image of the nightly news, these people cope with the disabilities caused by gun violence. They are our success stories, survivors of gun violence who, through medical rehabilitation, have returned to the community. Since this is a hearing on tax issues, I might note that as a result of the role of rehabilitation in returning individuals to independent lifestyles and reintroducing them into the work force, the government and the taxpayer have saved money because of reduced nursing home admissions, acute care hospitalization and long-term social service support.

All of us at Schwab know that we cannot completely control societal problems that lead to violence. At a minimum, we should ensure that the products that contribute billions of dollars to the cost of our health care system, such as guns, be appropriately and equitably taxed. The gun and ammunition excise taxes should be increased, with the additional revenues allocated to the Hospital Gunshot Cost Relief Trust Fund.

In closing, I would also invite you to visit Schwab as Mayor Richard Daley, and Congressmen Reynolds and Gutierrez have recently done, to witness the results that rehabilitation can have on the lives of victims. Additionally, information on rehabilitation's role in restoring independent lifestyles is being distributed to the committee members.

Thank you for allowing me to testify today.

Mr. KOPETSKI. Thank you for your testimony.

[The prepared statement follows:]

STATEMENT BY

Kathleen C. Yosko

President and Chief Executive Officer
Schwab Rehabilitation Hospital and Care Network
Chicago, Illinois

TUESDAY, JUNE 29, 1993

Good morning. As a member of the board of directors for the leading rehabilitation organizations -- the National Association of Rehabilitation Facilities, the Commission on Accreditation of Rehabilitation Facilities, the American Hospital Association Section for Rehabilitation Hospitals and Programs, and the Medical Rehabilitation Education Foundation -- I am proud to represent a cost-effective medical service that returns individuals to productive lives within their communities.

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Two-year-old Jonathan was snatched from his mother's side and shot through the head as he was used as a human shield. Gina, 19, was shot in the back while sitting in a parked car talking with her girlfriends. Steve, 24, was shot in the spine after a $9 robbery. Andre, 28, was paralyzed after being shot in the course of his work as a security guard. Jonathan, Gina, Steve and Andre, like many other patients whom we have treated, have returned to school, jobs and families.

It is on their behalf that Schwab supports Title III of H.R. 737 and similar legislation that would provide much needed assistance to hospitals in order to help cover the costs of providing medical care to gunshot victims.

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Schwab is the only rehabilitation hospital affiliated with three of the four adult Level I Trauma Centers in Chicago. As a result, we are likely to continue to see more individuals with gunshot injuries over the next year. During a six-month study period last year, more than 60% of patients admitted to Schwab for spinal cord injuries had been victims of violence. The vast majority of these were young people.

That is why we at Schwab have led an advocacy effort among hospitals and health care providers to reduce gun violence. Whether it be an accidental shooting of a child, a domestic violence firearms altercation, a job related gun incident, or a street exchange of gun fire, society -- and the taxpayer -- must ultimately bear the cost of treating the victims of gun violence.

Lifetime costs of treating a person with a serious spinal cord injury can be from three to five million dollars. As a rehabilitation hospital where Medicaid and Medicare -- in essence, the taxpayer -- pay for more than 80% of the care that we provide, guns have had a costly effect.

We applaud Congressman Mel Reynolds for his innovative legislative proposal to place more of the financial burden for the billions of dollars spent on treating gun shot victims by increasing the excise tax on the manufacturer, producer, or importer of firearms, shells or cartridges. This approach is consistent with the concept of other "user fees" currently being considered by Congress and in state legislatures.

It is important to point out that firearm violence, and its costs are not just a city problem. Christ Hospital, in the Chicago suburb of Oak Lawn, reported that in 1990, they treated only four gunshot wound victims from the suburbs. In 1991, that figure rose to 100, and grew to 140 in 1992. For reasons such as this, the Metropolitan Chicago Healthcare Council has fully supported H.R. 737. The Illinois Hospital Association has supported passage of a similar bill in the state legislature.

Our patients have faces and voices. Beyond the fleeting image of the nightly news, these people cope with their disabilities caused by gun violence. They are our success stories, survivors of gun violence who, through rehabilitation, have returned to the community. Since this is a hearing on tax issues, I might note that as a result of the role of rehabilitation in returning individuals to independent lifestyles and reintroducing them into the workforce, the government and the taxpayer save money because of reduced nursing home admissions, acute care re-hospitalization and long term social service support.

All of us at Schwab know that we cannot completely control societal problems that lead to violence. At a minimum, we should ensure that the products that contribute billions of dollars to the costs of our healthcare system, such as guns, be appropriately and equitably taxed. The gun and ammunition excise tax should be increased, with the additional revenues allocated to the Hospital Gunshot Cost Relief Trust Fund.

I also invite you to visit Schwab, as Mayor Daley, Congressmen Reynolds and Gutierrez have recently done. Additional information on rehabilitation's role in restoring independent lifestyles is being distributed to the committee members.

Thank you for allowing me to testify today.

Mr. KOPETSKI. Mr. Thayer is with the National Association for the Self-Employed.

Welcome.

STATEMENT OF BENNIE L. THAYER, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, NATIONAL ASSOCIATION FOR THE SELF-EMPLOYED

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

Mr. Chairman and Mr. Hancock, it is indeed a pleasure for me to appear here before this subcommittee today. The NASE is America's second largest business association with more than 320,000 members. Our members also come from every democratic-demographic category, the inner-city, suburban, rural, African-American, Hispanic and white. I myself come from a background of inner-city retail business, as do many of our members.

Some of our members are financially well off, while others are obviously struggling. But everyone is concerned about the cost and the quality health care today.

During the last year, considerable attention has been devoted to the concept of managed competition as a solution to America's health care problems. The White House Task Force on Health Care evidently backs some of it. Frankly, we have become highly skeptical of it, especially as far as inner cities and rural areas are concerned.

We believe that the basic structure of managed competition would lead to further decay of health care quality in inner cities and rural areas. As far as rural areas are concerned, this statement will not be surprising to those who have followed the health care debate. Even advocates of managed competition concede that in sparsely populated areas managed competition almost surely cannot work as advertised.

Would it work any better in inner cities? First, I ask you to consider some health care parallels between rural areas and inner cities. Like rural areas, inner cities have a high percentage of the elderly, a large population of transient workers at a near-poverty level, high rates of unemployment and a large proportion of low-paying jobs. For both small towns and inner cities, small businesses—even micro-businesses with fewer than five employees—make up a huge proportion of the employment base.

Mr. THAYER. Both city and country struggle to keep hospitals and clinics open and to recruit and retain health care professionals. Health care facilities in both areas serve percentages of government subsidized patients. The rural serving somewhat higher percentages of Medicare, the inner city somewhat higher percentage of Medicaid.

Facilities in both areas suffer from a public perception that their quality is low. How many middle class suburban Americans would want to be treated for a major ailment in either an inner city or a rural hospital, I ask you today?

Inner cities, though, have particular health problems, as we heard today, few rural areas suffer from high levels of AIDS, tuberculosis, infant mortality, and low birth weights, few have large non-English speaking populations, and few find their hospital

emergency rooms crowded with gunshot and knife wound victims, addicts, and street people.

Much of the cost of this care for these people is uncompensated, and that creates money shortfalls that make it harder for inner city facilities to attract and keep good doctors and nurses. This leads to perceptions and sometimes realities of poor quality which in turn discourages outside investment and on, and on, and on it goes, members of this committee.

We contend further that managed competition will actually make inner city health care worse. Here is why. A central concept in managed competition is scorecards. These scoring systems are supposed to rate doctors, hospitals, and health management systems.

How will these scorecards work, I ask you? Ratings will include such factors as low birth weights, infant mortality, vaccination rates, success ratios for various medical procedures, just to name a few. This means that inner city areas obviously are not going to score higher, and especially when doctors, because of the facilities in the inner city, and because of the lower financial return to them, will seek the more affluent areas to practice.

What is the surest path to higher scores for health care facilities? Ignore, turn away the sickest and the most indigent patients, avoid the crack babies, street people, the undereducated mothers and so on? We suggest that tinkering with the score system will account for the differences.

In conclusion, gentlemen, I offer an alternative approach for health care reform. To succeed, health care reform must be a part of a larger but more targeted focusing on resources which are available. An alternative approach to succeed, we feel, will be to put in rating systems that are sure that there are no roadblocks to the quality of health care for people living outside of certain favored areas.

Opponents of the insurance industry have focused on what is known as the cherry picking of the insurance industries. I am suggesting to you today that managed competition will indeed cause cherry picking of certain demographic areas if it is installed, certainly in the inner city area as well as has been shown in the rural area.

Instead, we should bring the best health care system possible to the inner city community. I suggest to members of this committee that you consider the tax advantaged Medisave accounts. Together, with a system of vouchers, this could empower inner cities' health care consumers to seek quality health care and provide inner city health care providers with continuing cash flow they need to grow and to improve their quality.

I have submitted a longer statement for the record, Mr. Chairman, and I conclude this statement now and am available for any questions.

Mr. KOPETSKI. Thank you, and the entire panel's complete testimony will be made a part of the record.

[The prepared statement follows:]

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"Serving the Needs of Small-Business America"

STATEMENT

TESTIMONY OF

BENNIE L. THAYER
CHAIRMAN AND CEO
NATIONAL ASSOCIATION FOR THE SELF-EMPLOYED

BEFORE THE
SUBCOMMITTEE ON SELECT REVENUE MEASURES
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

29 JUNE 1993

INNER CITY HEALTH CARE PROBLEMS: WHY "MANAGED COMPETITION" WON'T WORK

Mr. Chairman, members of the Subcommittee, thank you for inviting me to appear here today. I am Bennie L. Thayer, Chairman and CEO of the National Association for the Self-Employed. NASE is America's second-largest business organization, with more than 320,000 members, including more than 25,000 in the state of New York. Our members come from all sectors of the economy -- retail, wholesale, services, manufacturing, agriculture, transportation and construction. Perhaps more important, for purposes of today's hearing, our members also come from every demographic category -- inner city, suburban, rural, African-American, Hispanic, white. I myself come from a background of inner city retail business, as do a number of our members. Some of our members are financially well-off; while others are struggling. But every one is concerned about the costs and quality of health care today. (Of course, they have other concerns, too. I am submitting another statement for the Subcommittee's consideration, dealing with some tax issues in the reconciliation bill.) In my oral statement today, however, I want to focus on health care.

Since this morning's hearing began, the Subcommittee has heard from a variety of witnesses about health problems afflicting the inner city. Those problems are real, and they deserve the nation's attention. I would like to concentrate on some possible *solutions* to those problems.

Managed competition. During the last year, considerable attention has been devoted

to the concept of "managed competition" as a solution to America's health care problems. The White House Task Force on health care evidently backs some form of it. Frankly, we have become highly skeptical of it -- especially as far as inner cities and rural areas are concerned.

We believe that the basic structure of managed competition would lead to further decay of health care quality in inner cities and rural areas. As far as rural areas are concerned, this statement will not be surprising to those who have followed the health care debate. Even advocates of managed competition concede that in sparsely populated areas with few doctors, clinics, and hospitals, managed competition almost surely cannot work as advertised. The whole notion of a few giant, vertically-integrated HMO's and insurance company oligopolies (the so-called Accountable Health Plans, or AHP's) competing with one another for huge blocks of business simply is not feasible in rural America. Would it work any better in our inner cities?

First, consider some health care parallels between rural areas and inner cities. Like rural areas, inner cities have a high percentage of the elderly, large populations of transient workers at or near poverty level, high rates of unemployment and a large proportion of low-paying jobs. For both small towns and inner cities, small businesses -- even micro-businesses with fewer than five employees -- make up a huge proportion of the employment base.

Of those with health insurance, both inner city and rural residents are more likely (than suburban residents) to pay for it themselves. Transportation difficulties can create roadblocks to care in both areas. A rural resident driving 100 miles down open road to get good health care is roughly equivalent to an inner city resident spending two hours on public transportation to get good health care.

Both city and country struggle to keep hospitals and clinics open, and to recruit and retain health care professionals. Health care facilities in both areas serve high percentages of government-subsidized patients -- the rural serving somewhat higher percentages of Medicare, the inner city somewhat higher Medicaid. Facilities in both areas suffer from a public perception that their quality is low. How many middle-class suburban Americans would want to be treated for a major ailment in either an inner city or a rural hospital?

Inner cities, though, have particular health problems -- as we've heard today. Few rural areas suffer from high levels of AIDS, tuberculosis, infant mortality and low birthweights. Few have large non-English speaking populations. And few find their hospital emergency rooms crowded with gunshot and knife wound victims, addicts, and street people.

When these acute inner-city health problems are mixed with low-paying jobs and chronic unemployment, the result is health care facilities providing more care for indigents. The cost of indigent care must be passed on to someone, particularly if public funding sources leave a gap. So "cost-shifting" occurs, to those with insurance or adequate funds of their own. HMO's and insurance companies know this, so they often try to steer their patients away from these health care facilities.

The money shortfalls, in turn, make it harder for inner city facilities to attract and

keep good doctors and nurses. This leads to perceptions (and sometimes realities) of poor quality, which in turn discourages outside investment. On and on it goes.

So I return to my question: **Do adequate facilities exist in the inner city to support the managed competition vision?** Do inner cities offer huge health care provider networks available to compete with one another for large blocks of business -- any more than rural areas do?

We contend that the answer is no. We believe, further, that managed competition will actually make inner city health care worse.

Here's why. A central concept in managed competition is "scorecards." These scoring systems are supposed to rate doctors, hospitals, and health management systems on their ability to deliver quality care. The idea is that consumers, and the provider/insurance company oligopolies, then can use the scorecards to pick the best health care facilities for the money.

How will these scorecards work? Ratings will include such factors as low birthweights, infant mortality, vaccination rates, success ratios for various medical procedures, to name a few. Facilities that deliver crack babies, treat the homeless, or care for the poor aren't going to score very well on these tests. And facilities with the best scores aren't going to risk those top scores by reaching out to the inner cities. In medical terms, managed competition's scoring system will make the rich richer and the poor poorer. A handful of affluent facilities in each metropolitan area will monopolize the best scores, and therefore generate the most demand from the AHP oligopolies. This will lead to the high scorers participating in more AHP's and attracting more patients. From that patient base will flow more of the best doctors, more outside investment, etc. Lower-scoring facilities will face exclusion from the AHP oligopolies and/or avoidance by patients, doctors and investors. Once the downward spiral starts, there will be little hope of stopping it. Managed competition theory is so intent on preserving the AHPs' oligopoly status that any individuals or employers foolhardy enough to try to operate outside the AHP's are severely punished with fines and tax penalties. So everyone must join the AHP's and the AHP's must have high scoring facilities to attract the patients they need. Competition among the two or three AHP's in any given area to offer the highest-scoring facilities at the lowest prices is the essence of managed competition. (There are many ways to bring down prices for medical care and not all of them are attractive from a consumer standpoint. AHP oligopolies surely cannot be depended upon to choose the most attractive.) But for now, let us concentrate on how the oligopolies would get their scores up.

What is the surest path to higher scores for health care facilities? Ignore or turn away the sickest and most indigent patients. Avoid the crack babies, street people, undereducated mothers, etc., who are sure to bring down a facility's scores.

Tinkering with the scoring system to "account for differences" between facilities

probably won't work either. AHP's would likely be able to spot where the tinkering had occurred, and recalculate the figures to arrive at the "correct" scores. Moreover, tinkering would undermine consumer trust in the basic scoring system. This would have devastating "ripple" effects on public confidence in other parts of the managed competition formula -- such as the quality of the health care its supposedly provides and its alleged ability to provide superior value for the money spent.

Managed competition won't reward compassion. It will reward selection. The inventors of managed competition, who relentlessly attack risk selection of *individuals* in the health insurance industry (inevitably calling it "cherry picking") are creating a system that rewards and practically forces doctors, clinics, health care plans, and even hospitals to "cherry pick" entire *categories* of patients and entire *areas* of cities.

Those already best served by America's health care delivery system might do even better under managed competition. The upper middle class, suburban, and well-educated, who are conscious of good health habits and secure in their jobs and their environment *could* be the winners. That is, if *other* parts of the managed competition concept work as advertised -- a big if. The losers, even if the system otherwise works as advertised, will be those already on the fringe of health care -- the poor, ethnically diverse, under-educated populations of the inner cities.

An Alternative Approach. To succeed, health care reform must be part of a larger, but more targeted, focusing of resources and opportunity. We must better reward health care professionals, financially and spiritually, for practicing in the inner cities. We must expand centers of health care excellence and place them within the reach of the medically underserved.

We must assure that "rating systems" do not become roadblocks to quality health care for people living outside certain favored areas. Perhaps most importantly, health care reform must build upon today's system in maximizing, not minimizing, choices.

Within these areas of underemployment and unemployment, we must not look to a system of employer-provided health insurance to solve all the problems. Marginal inner city businesses will be forced to lay off workers or close their doors if they must take on the added payroll burden of health insurance, and significant segments of the population -- the unemployed and many students, for example -- will be left out altogether.

Instead, we should bring the best health care possible into the community, then empower people to use it. Tax-advantaged Medisave accounts, together with a system of vouchers, could empower inner city health care consumers to seek quality health care -- and provide inner city health care providers with the continuing cash flow they need to grow and to improve their quality. Improve inner city health care facilities, then put health care spending power in the pockets of inner city residents. Give the inner city the economic muscle to improve its own health.

There are other targeted reforms which would help solve specific problems. We should increase the tax deduction for health insurance purchased by the self-employed to the same 100% that all other businesses get. That would put health insurance within the financial reach of millions more Americans. We should require health insurance to be both portable and guaranteed renewable. We should ban selective rate increases and selective cancellations of individual and group health insurance policies. We should expand state high risk pools for the medically uninsurable, and establish a national high risk pool. We should restrict physician self-referral. These targeted and achievable reforms would go a long way toward providing the affordable and accessible health care all Americans deserve.

Mr. Chairman, that concludes my testimony. I would be happy to take any questions at this time.

Mr. KOPETSKI. Mr. Gardiner from the NRA.

STATEMENT OF RICHARD GARDINER, LEGISLATIVE COUNSEL, NATIONAL RIFLE ASSOCIATION

Mr. GARDINER. Mr. Chairman and members of the subcommittee, I appreciate the opportunity to present the views of NRA's 3.2 million members and their families.

The NRA is unequivocally opposed to increasing taxes on firearms and ammunition to recover the costs of the consequences of criminal activities. We believe that such assessments are inappropriate since they will increase traffic in the illicit firearms market, they will impact on the ability of honest citizens, particularly those in the lower end of the economic scale, to afford firearms for self-protection, and they will impair established State wildlife management and education programs which are served by existing excise taxes.

Mr. Chairman, sportsmen and women have paid their own way. Forty-six years ago at the urging of sportsmen, Congress passed the Wildlife Restoration Act, commonly called Pittman-Robertson. This act levies excise taxes on firearms and ammunition. Since its passage in 1937, Pittman-Robertson has provided funding to the Federal Aid to Wildlife Restoration Fund which allocates funds to State fish and game departments to support "comprehensive fish and wildlife resources management plans which shall ensure the perpetuation of these resources for the economic, scientific, and recreational enrichment of all the people."

The success of this levy is such that since 1937 hunters have generated some $2.5 billion to support wildlife conservation and hunter safety through habitat purchase and management, range development, and research on game and nongame species. If license and user fees are included, the total is over $3 billion.

Money from Pittman-Robertson and from hunting and related activities provides 75 percent of the average budget for State wildlife agencies. Needless to say, the benefits which accrue to our Nation are not monopolized by the sporting community, but are enjoyed by Americans from every walk of life.

Now it has been suggested by proponents of various revenue raising proposals—individuals who are demonstrably opposed to the idea of Americans owning firearms—that it is appropriate to raise taxes on firearms, particularly handguns and ammunition, to recover the health care costs of violence to society.

The essential premise on which the proponents base these proposals is that taxes on gun buyers are justified because firearms are inherently evil and that these taxes are in reality a form of user fee. The proposed Hospital Gunshot Cost Relief Trust Fund in section 302 of H.R. 737 is an amendment to the trust fund code which provides trust funds for black lung disability, airports and highways, oil spill liability, and other purposes.

H.R. 737, which proposes to increase the excise tax to 20 percent on firearms, represents a misuse of the trust fund concept since under that concept funds are put aside to be spent on projects to benefit the payers of the tax, as the examples I have mentioned.

Moreover, such an exorbitant tax would substantially reduce legal demands for firearms. Hence funds which are currently di-

rected into the Pittman-Robertson will fall significantly. H.R. 737 would thus substantially wreck the system of wildlife restoration funding which has been in place for over 50 years, even though no funds would be directly taken out of that fund.

Mr. Chairman, H.R. 737 is also grounded on faulty assumptions. Current medical costs nationally exceed $800 billion a year. As you heard earlier, the AMA estimates that the total cost of treating gunshot wounds is on the order of $1 billion. These numbers include accidents, attempted suicides, criminally inflicted injuries, as well as those inflicted in self-defense or justifiably by police or private citizens.

Indeed, it has been estimated by Professor Kleck of Florida State University that there are approximately 1.4 million instances annually of the defensive use of firearms in the United States, 645,000 of them involving handguns. Professor Kleck has noted the possibility that more lives are saved by protective uses of firearms than are taken in suicidal, homicidal and accidental misuse. Certainly numerous injuries which would otherwise require medical care are prevented by lawful gun ownership.

The vast majority of criminals inflicting injuries would not, moreover, even be paying the "user fee." Those who were not abusive of firearms would be. We know from the Wright-Rossi felon survey that only 16 percent of criminals get their firearms either directly or indirectly from retail outlets, and I might note that many of those get them indirectly through having a lawful purchaser make the purchase. We also know that the figure falls to about 7 percent when we are talking about the more serious criminals who commit crimes over and over again and presumably do much more than their share of injury. And in cities like Chicago, where handguns are completely banned, but where the majority of crimes occur, the number will certainly be even lower. Thus the excise tax would be by and large not be paid by those who would commit the injuries.

And I might note, since the question of juveniles has been mentioned frequently, that since it is illegal for juveniles to buy firearms from retail outlets at all that the juveniles who are using firearms to commit crimes will certainly not be affected at all. Based on Professor Kleck's estimate of the numbers injured in self-defense and justifiable shootings by civilians and the total number of gunshot wounds requiring emergency room or hospital treatment, such injuries could account for somewhere between 7 to 25 percent of injuries.

Why should the law abiding gun owner alone bear the burden of providing for the medical treatment of a criminal shot by a policeman or a private citizen in self-defense? It is akin to billing a car's owner for injuries a car thief suffers when crashing the stolen car. Indeed, it is worse arguably since injuring the criminal provides a public service by at least temporarily having an incapacitating effect, preventing the criminal from committing more crimes, and giving the State an opportunity to prosecute him for the crimes he has committed.

Mr. Chairman, to increase the excise tax will do what the proponents hope, it will dampen lawful retail sales of firearms, but for whom primarily? The exercise of second amendment rights will more than ever be premised, then, on a person's income. If enacted,

these proposals will certainly drive away those who can now just afford to participate in lawful activities such as hunting or target shooting. This is those in the lower end of the socioeconomic scale for whom owning a firearm for self-protection is not a luxury.

Moreover, if the spillover economic impact is factored in, and I would suggest that the recent experience of the so-called luxury taxes be examined, there will be ramifications throughout every facet of the sporting equipment industry.

Mr. Chairman, many in our society are increasingly unable to determine right from wrong. Our morgues are filled with object lessons exemplifying not the outcome of lawful firearms ownership, but the failure to inculcate an increasingly large segment of society with proper moral foundations, or failing that, to instill respect for law and the certainty of swift and certain punishment as a meaningful deterrent to law breakers. And the crime rates in cities like New York and Chicago, which have been mentioned over and over again this morning in this hearing, demonstrate starkly the failure of gun control laws as a mechanism for reducing crime.

A recent survey indicates that 88 percent of the American people believe what the empirical evidence proves, that the criminal justice system is broken and needs major reform. As one proof, I would point to the declining average amount of time spent by criminals behind bars. When the expected costs for murder breaks down to 1.8 years in prison, violent crimes will continue.

The Congress would do a greater service in dramatically increasing the overall security of the community if it were to address the real issue of lax criminal justice rather than seeking additional funding to pay for the consequences of that lax criminal justice system.

H.R. 737 seeks to punish law abiding citizens economically for crimes they have not committed and will deprive the States of important wildlife and recreation benefits. There probably could not be an issue better poised to unite all sportsmen and firearms owners against it than this one.

Thank you.

Mr. KOPETSKI. I want to thank all of you for your testimony.

[The prepared statement follows:]

STATEMENT OF RICHARD GARDINER, LEGISLATIVE COUNSEL,
NATIONAL RIFLE ASSOCIATION OF AMERICA,
INSTITUTE FOR LEGISLATIVE ACTION

Mr. Chairman and members of the Subcommittee, I am Richard Gardiner, Legislative Counsel for the Institute for Legislative Action of the National Rifle Association of America. I appreciate the opportunity to present the views of our 3.2 million members.

Jean Baptiste Colbert wrote several hundred years ago that, "The art of taxation is in so plucking the goose as to obtain the largest possible amount of feathers with the smallest amount of hissing." The proposals before this Subcommittee prove that the centuries have wrought little change in govemment or goose plucking -- its still a matter of trying to find the right bird.

The NRA believes that the premise of the various proposed excise tax increases on firearms and ammunition is flawed. For the record, we are unequivocally opposed to increasing taxes on firearms, ammunition, and or any other lawfully manufactured product, as a penalty to recover the costs of the consequences of criminal activities. We believe that such assessments are inappropriate when examined in light of the impact they will have in creating increased traffic in the illicit firearms market; the impact they will have on the ability of honest citizens -- particularly those on the lower end of the economic scale -- to afford firearms they may require for self-protection; and the impact they will have on established state wildlife management and education programs which are served by existing excise taxes on firearms and other related products.

Mr. Chairman, sportsmen and women pay their own way. Like most Americans, they don't mind paying taxes when the goals are worthy, the levies fair, and the funds used for the purpose for which they are collected. I believe the historical record provides ample proof of the validity of this proposition.

Forty-six years ago, at the urging of sportsmen, Congress passed the Wildlife Restoration Act of 1937. Commonly called Pittman-Robertson (or "PR"), the Act levied a 10% excise tax on rifles, shotguns, and ammunition. In 1971, a 10% tax was levied on handguns. In 1975, again with the support of sportsmen and the industry, the law was amended and expanded to encompass archery equipment and raised to 11%, and a portion of the revenues were channeled to support hunter safety training and range development.

Since its passage in 1937, the PR funding has provided funding to the Federal Aid to the Wildlife Restoration Fund managed by the Treasury. 16 U.S.C. §§669 et seq. Amounts in the Fund are allocated to state fish and game departments to support wildlife restoration and "comprehensive fish and wildlife resources management plan[s] which shall insure the perpetuation of these resources for the economic, scientific, and recreational enrichment of the people." §669e. "The term 'wildlife-restoration project' shall be construed to mean and include the selection, restoration, rehabilitation, and improvement of areas of land or water adaptable as feeding, resting, or breeding places for wildlife . . . ." §669a.

Most importantly, all revenues from taxation of firearms and ammunition are allocated to wildlife restoration. §669b(a) of the Act provides:

> An amount equal to all revenues accruing each fiscal year (beginning with the fiscal year 1975) from any tax imposed on specified articles by sections 4161(b) [bows and arrows] and 4181 [firearms and ammunition] of Title 26, shall, subject to the exemptions in section 4182 of such Title, be covered into the Federal aid to wildlife restoration fund in the Treasury (hereinafter referred to as the "fund") and is authorized to be appropriated and made available until expended to carry out the purposes of this chapter. (Emphasis added.)

The success of this levy is such that since 1937, hunters have generated approximately $2.5 billion to support wildlife conservation and hunter safety through habitat purchase and management, range development, and research on game and non-game species. If license and user fees are included, the total is over $3 billion.

The support for these programs has come from the knowledge that the money was placed in trust and used to help pay for the acquisition and management of wildlife areas and related programs for the benefit of present and future generations of Americans. There are those who disparage the idea of the hunter as conservationist, but the simple truth is that the money from PR and from hunting and related activities provides, according to the Wildlife Management Institute, 75% of the average budget for state wildlife agencies. Needless to say, the benefits which accrue to our nation are hardly monopolized by the sporting community but are enjoyed by Americans from every walk of life.

Now it has been suggested by proponents of various revenue raising proposals -- individuals who are demonstrably opposed to the idea of Americans owning firearms -- that it is appropriate to raise taxes on firearms, particularly handguns and ammunition, to recover the "health-care costs" of violence to society. The essential premise on which the proponents base these proposals is that taxes on gun buyers are justified because firearms are inherently bad, and that these taxes are in reality a form of "user fee". Several bills have been introduced in Congress which provide for this in one form or another. We categorically reject this idea.

The proposed Health Care Trust Fund, set forth in Section 4 of S. 868, "The Firearms Victims Prevention Act," and the Hospital Gunshot Cost Relief Trust Fund in Section 302 of H.R. 737, "The Strict Liability for Safer Streets Act," are to be amendments to the Trust Fund Code, Subchapter A of Chapter 98 of the Internal Revenue Code, 26 U.S.C. §§9501 et seq. The Code also provides trust funds for black lung disability, airports and highways, oil spill liability, and other purposes. \

S. 868 and H.R. 737 -- which propose to increase the excise tax to 25% on many firearms and ammunition -- represent a misuse of the trust fund concept since, under that concept, funds are put aside to be spent on projects to benefit the payers of the tax. Moreover, such an exorbitant tax would undoubtedly substantially reduce demand for such products. Hence, funds which are currently directed into PR will fall significantly. S. 868 and H.R. 737 would thus substantially wreck the system of wildlife restoration funding which has been in place for over fifty years.

It is also instructive to note that, since the procedural mechanisms for administering the anticipated funds from these bills are either vague or non-existent, these bills would construct a new source of discretionary congressional spending, with little certainty that the money collected would be spent for the purpose for which it was collected.

Mr. Chairman, these bills would not only abuse the trust fund concept and impair ongoing wildlife restoration efforts, they are grounded on faulty assumptions.

Current medical costs nationally exceed $800-billion per year. The various estimates for the costs of treating gunshot wounds is $500-million to $4-billion -- although $2 billion is probably reasonable, based on a Center for Disease Control (CDC) estimate of no more than 105,000 gunshot wounds annually treated by emergency rooms and hospitals, and a variety of studies putting the cost at $12-18,000 per gunshot-wound patient. Handguns, according to the Bureau of Justice Statistics study, "Handgun Crime Victims" (July 1990), are involved in about 15,000 criminally-inflicted non-fatal shootings annually. In addition, there are about 13,000 criminal homicides, some of which require medical care. But these numbers include accidents, attempted suicides, criminally-inflicted injuries, as well as those inflicted in self-defense or justifiably by police or private citizens.

By comparison, I would note that the cost of treating nosocomial infections (blood infections occurring in the hospital itself and not carried into the hospital by the patient) is estimated to be $5-billion per year and to result in 30,000 deaths annually -- nearly as many as the total number of gun-related deaths annually (34,000). Other products for which higher "sin taxes" are proposed -- tobacco and alcohol -- are associated with roughly 400,000 and 100,000 deaths annually. And there are about 40,000 motor vehicle deaths annually, plus about **two million** serious injuries.

But, while taxing automobiles, alcohol, or tobacco might have beneficial effects in reducing use -- saving energy and reducing accidents, morbidity and mortality -- anything intended to restrict law-abiding citizens from acquiring and using firearms may well increase morbidity and mortality of the law-abiding at the hands of the criminal by reducing firearm use for protection. The impact of this regressive tax will, as always, be particularly felt on the lower end of the economic scale.

It has been estimated, based on surveys developed, conducted, and interpreted by Prof. Gary Kleck, of Florida State University that there are approximately 1.4 million instances annually of the defensive use of firearms in the U.S., 645,000 of them involving handguns. Prof. Kleck has publicly noted the possibility that more lives are saved by protective use of firearms than are taken in suicidal, homicidal, and accidental misuse; certainly numerous injuries, which would otherwise require medical care, are prevented.

The vast majority of criminals inflicting injuries would not, moreover, be paying the "user fee"; those who are not abusive of firearms would. We know from the Wright-Rossi felon survey that only 16% of criminals get their firearms by purchase (directly or indirectly) from retail outlets. We also know that the figure falls to about 7% when we are talking about the more serious criminals who commit crimes over and over again and presumably do much more than their share of injuring. In short, the fee would not be paid by those who injure people using a handgun more than, say, 10% of the time. And handgun injuries constitute a minority of the injuries inflicted in the course of crime. A recent Bureau of Justice Statistics study notes that a serious injury is inflicted in 4.5% of handgun victimizations, but in 4.9% of non-handgun-related criminal victimizations -- which constitute 90% of the victimizations. This means that handguns are involved in less than 10% of the criminal victimizations which result in serious injury. With the tax paid by roughly 10% of handgun-abusing criminals, this means that about 1% of the serious injuries involve handgun abuse by a criminal who paid the tax.

There are some 65-million handguns in private hands in this country. So, over the course of an entire year, perhaps one-tenth of one percent of handguns are used to injure someone to the degree that the medical care of concern to this proposal is involved. Even multiplying by ten (the Police Foundation's 1977 study, Firearm Abuse, suggested that at least 90% of crime guns are less than ten years old), only 1% of taxed handguns would be misused in the course of the decade.

Based upon Kleck's estimate on the number injured in self-defense and justifiable shootings by civilians (as many as 16,000) and the total number of gunshot wounds requiring emergency-room/hospital treatment (up to 105,000), such injuries could account for 7-25% of injuries -- probably closer to the lower figure, if only because many of those injured while committing criminal acts will avoid medical care, if at all possible, since it can only attract the attention of the authorities. Should the law-abiding gun owner alone to bear the burden of providing for the medical treatment of a drug trafficker shot by another drug trafficker, or a criminal shot by a policeman or by a private citizen in self defense? It's akin to billing a car's owner for injuries a car thief suffers when crashing the stolen car -- worse, arguably, since injuring the criminal provides a public service by at least temporarily having an incapacitating effect, preventing the criminal from committing more crimes, and giving

the state a chance to prosecute him for crimes he has committed, including the one where a citizen gunshot, in effect, arrested the culprit. What has happened to the concept that criminals should pay for their crimes? This concept stands that tenet on its head.

In addition, if ever there was a more likely way of increasing the volume of transactions outside of the licensed firearms dealers than raising excise taxes and hence the retail cost of the firearm, I cannot envisage what it might be. Those most inclined to misuse firearms, and most likely to acquire firearms by illicit means, will likely little notice or care about an increase in price. More to the point, not one dollar from the sale of an illegal firearm will be put to any of the suggested worthy uses.

Mr. Chairman, it should also be noted that, to the extent the market for firearms is governed by the commonly accepted rules of supply and demand, increasing the cost of supply will exacerbate related problems. Firearms are a fungible commodity. By increasing the cost, you bring sellers into the market. Since criminal demand is relatively inelastic, competition should intensify as profit margins increase. If the drug market is an apt comparison, the illegal handgun market will no doubt become more violent.

To increase the tax above the existing 11% tax, even without the transfer taxes, will likely do what proponents hope: dampen lawful retail purchases. But for whom? The exercise of Second Amendment rights will be, more than ever, premised on a person's income. In enacted, these proposals will certainly drive away those who can now just afford to participate in lawful activities such as hunting or target shooting. This is those on the lower end of the socio-economic scale for whom owning a firearm for self-protection or to supplement the supply of meat in the freezer is not a luxury. Furthermore, if the spill-over economic impact is factored in, and I would suggest the recent experience with the so-called "luxury taxes" be examined, there will be ramifications throughout every facet of the sporting equipment industry.

And, to what end? Since the vast majority of guns and ammunition that are lawfully purchased are not used in crimes, any new taxes will serve only to have the lawful pay for the deeds of the unlawful. This kind of a tax, whether it is to raise general revenues or used to pay for a specific program is being commonly called a "sin tax". If paying for the sin is the question, I can tell you the law abiding citizen is not the answer. Rather, it would be more relevant in searching for funds to pay for a national health care program to look at the crime victims restitution fund which directly links the criminal to the consequences of his crimes.

I would also like to draw your attention to another issue that arises with the legislation previously mentioned. Specifically, one bill creates an unprecedented new federal retail sales tax extending its reach to every firearm in existence in the chain of distribution at the time the tax is implemented. Each subsequent private transfer after the first retail sale would be taxed at the same rate.

It is not likely that the cost of collecting a transfer tax will recover the Government's cost of implementing this program. Manufacturers and importers are knowledgeable about the present excise tax requirements because they are already paying those taxes. But I seriously question the extent to which this same knowledge is present in the average consumer, particularly since the tax is normally "hidden" from them in the price of the item. Thus, imposition of a requirement that ordinary members of the public should file a tax form and pay a tax on a simple transfer, particularly if it is on a firearm that has been in their possession for some time, would likely result in extremely low compliance. If one surveys the ability of law enforcement to police private transfers, the rate of non-compliance will likely be as high. Furthermore, even those who do comply might not be adding any net revenues to the U.S. Treasury. For instance, a $100 dollar sale with a $25 dollar tax fee filed with Treasury is going to require a one time paper work burden which will likely cost

more than the money it generates.

Mr. Chairman, many in our society are increasingly unable to determine right from wrong. America's morgues are filled with object lessons exemplifying not the outcome of lawful firearms ownership, but the failure to inculcate an increasingly large segment of society with the proper moral foundations, or failing that, to instill respect for the law and of the certainty of swift and certain punishment as a meaningful deterrent to law breakers. A recent Luntz-Weber survey indicates that 88% of the American people believe what the empirical evidence proves -- that the criminal justice system is broken and needs major reform. As one proof, I would point to the declining average amount of time spent by criminals behind bars as documented by Morgan Reynolds of the National Center for Policy analysis. When the expected cost of a murder breaks down to 1.8 years in prison, violent crimes are not being treated seriously by society. Furthermore, to suggest that there are no limits on guns is to ignore the reality of the twenty thousand plus laws governing the use and abuse of firearms already in existence.

This Congress would do a greater service, and dramatically increase the overall economic security of the community, if it would address the real issue of lax criminal justice, rather than seeking additional funding to pay for the consequences of the same. These are proposals which seek to punish law-abiding citizens economically for crimes not committed on one hand, and on the other hand, rob the states of important wildlife and recreation benefits. No one is going to stand by and watch a 56 year investment wither away without a fight. There probably could not be an issue better poised to unite all sportsmen and firearm owners against it than this one.

Mr. KOPETSKI. I have some questions Mr. Gardiner, do the gun manufacturers pay corporate taxes?

Mr. GARDINER. Certainly they do.

Mr. KOPETSKI. And the retailers pay corporate or propriatary taxes?

Mr. GARDINER. Certainly.

Mr. KOPETSKI. So this is just like any other business in the United States, they pay taxes?

Mr. GARDINER. Absolutely.

Mr. KOPETSKI. Then on top of that there is an excise imposed on them?

Mr. GARDINER. On the sale of firearms, that is correct.

Mr. KOPETSKI. The excise tax revenue is used for Pittman-Robertson and specifically what are those funds used for?

Mr. GARDINER. They are used primarily for wildlife restoration and as I quoted from the statute, "comprehensive fish and wildlife resources management plans which shall ensure the perpetuation of these resources for the economic, scientific, and recreational enrichment of the people."

Mr. KOPETSKI. In my State the State legislature has jurisdiction over dividing up how these funds are spent. Is that usually the case throughout the country?

Mr. GARDINER. Yes.

Mr. KOPETSKI. So a representative body determines priorities among those different allocations?

Mr. GARDINER. Consistent with Federal law, yes.

Mr. KOPETSKI. And this, as your testimony noted, was a tax, if you will, that was asked for by sportsmen and women and agreed to by the manufacturers?

Mr. GARDINER. That is correct, because it was going to be used for a beneficial purpose, not only for those sportsmen, but as I noted for all of society to purchase areas and to preserve wildlife for the enjoyment of everyone.

Mr. KOPETSKI. That is such as wetland areas for bird sanctuaries, et cetera, which has a beneficial effect on the environment overall. In addition, the Ducks Unlimited, for example, folks are able to go hunting?

Mr. GARDINER. That is correct.

Mr. KOPETSKI. Have the resource.

Mr. Beard, do you think, then-you call this a subsidy to the firearms industry. Do you think that is a proper description of this?

Mr. BEARD. I certainly do. When you look at the way the program has been administered in the States across the country, and it is no longer a valuable program given the nature of gun violence in our society, that thousands of people are dying—every 2 years we have killed more Americans with guns than were killed in the war in Vietnam.

Something has got to be done to deal with that problem.

Mr. KOPETSKI. Let me ask, your characterization of this as a subsidy, you are recognizing that this is not from the general taxpayers?

Mr. BEARD. Absolutely.

Mr. KOPETSKI. OK. So this isn't taking general revenues and helping any particular industry?

Mr. BEARD. But it is, in fact, promoting the products of the firearms industry, and at a time when we have children afraid to go swimming in the District of Columbia because of one 17-year-old kid with a gun, we have got to look at whether or not we want to continue promoting the firearms industry in America.

Mr. KOPETSKI. Do you think there is any environmental benefit to this program?

Mr. BEARD. I think there are very good environmental benefits to the program. We have reaped a lot of benefits from that program. It is time now that the medical industry reap some of the benefits from the program as well as the expenses that they have had to bear.

I point out to you that we have had to pay, the taxpayers have to pay roughly 80 percent, 80 to 85 percent of the cost of gunshot victims. That is why so many trauma centers have gone out of existence over the last 5 or 6 years. That is a terrible cost to society.

Mr. KOPETSKI. Mr. Gardiner's testimony was that approximately 16 percent of the criminals receive their guns from unlawful purposes. Would you accept that that is roughly a correct ballpark figure?

Mr. BEARD. I assume that to be correct. I don't see that that has any impact on the issue here, and that is whether or not we ought to take some of this money and use it to pay back the cost of gun violence created by the manufacturers and dealers and users of firearms.

Mr. KOPETSKI. Well, you don't think, then, there is any relevance to the fact that 84 percent of the people who purchase firearms are using those in lawful purposes and you are asking them to subsidize hospitals in Chicago or New York or Los Angeles or Washington, D.C.?

Mr. BEARD. Absolutely because they have been asking us to help subsidize their programs for generations. This is just a return.

Mr. KOPETSKI. How are they asking you to subsidize their programs? Where is that subsidy coming from?

Mr. BEARD. First of all, the subsidy comes from the Pittman-Robertson program which they themselves are paying, as you are getting at, but clearly States—the Federal Government has subsidized the defense civilian marksmanship program for many years, the State subsidized local hunting and sports programs.

There are State subsidies and Federal subsidies to the hunting industry, the manufacturing industry. We are Americans. We all have got to be concerned about what happens to everybody, not just a small portion of us.

Mr. KOPETSKI. Doesn't everybody's tax dollars go toward Medicaid and Medicare programs in this country?

Mr. BEARD. Absolutely, and as I say, we are paying an inordinate fee because of the misuse of guns in our society, and we think that the people who manufacture and sell those guns ought to pay some of the cost.

Mr. KOPETSKI. Even though 85 or 84 percent of the people that are using these guns are using them in a legal manner and not harming other people?

Mr. BEARD. Well, I think you are making an erroneous assumption, saying it is 84 percent. The 16 percent was simply those who

get the guns outside the system. When you look at the number of guns that are misused, the number of people who die, the number of children who die every day in our society by previously law abiding people who just simply get angry or frightened and pick up a gun, that is what we have got to look at, is not just those who don't misuse the gun, but the thousands of people who die every year, some 32,000 Americans die a year from gun violence. That is too great a price for us to pay right now.

Mr. KOPETSKI. And there is a distinction between use of handguns and use of rifles.

Mr. BEARD. Absolutely.

Mr. KOPETSKI. The proposed tax would include long rifles as well. Are you saying that you are supportive of that tax as well?

Mr. BEARD. That is an area that we would be willing to work with the committee on some compromise. We are concerned particularly about the handguns. We are interested in the tax on handguns and assault weapons, the paramilitary style assault weapons.

It could be a very open question what we do with legitimate sporting guns, rifles and shotguns.

Mr. KOPETSKI. Is the purpose of your support of this legislation to impose a tax to deter people from purchasing handguns or is it a method of financing trauma centers?

Mr. BEARD. It is obviously both. We don't want people to use guns, and as I said in my testimony several times, that if that is the consequences of this tax, it is a good consequence, it would reduce the amount of money we have to spend on the medical program, so we want to do both, absolutely.

Mr. KOPETSKI. Are you aware of the fact that in many rural—in many urban areas because of the urbanization and the fact that people do have guns, legitimate sportsmen and women—that there are few places for them to target practice or to use their weapons in a sportsmanlike manner, target practicing just for the fun of it, that Pittman-Robertson fund goes to these kind of places as well so that people aren't trespassing on private lands or endangering others and shooting in areas that may be dangerous to the public?

Are you aware?

Mr. BEARD. Absolutely, but I would say you have got to look at the whole issue.

Mr. KOPETSKI. Sorry, I haven't asked the question. You have to wait for the question before you can answer it. Do you think that is a legitimate use of these dollars?

Mr. BEARD. I think it has been a legitimate use. I think we now have to ask ourselves is there a better use for those funds, is it more appropriate now because of the level of gun violence to spend the money to deal with the problem we have and to reduce the market for firearms in the United States.

Mr. KOPETSKI. Well, are you suggesting, then, that we should not fund shooting ranges any longer?

Mr. BEARD. I think that there are a number of urban shooting ranges. There is one I saw recently in Los Angeles. If people want to join shooting ranges, they should pay for the privilege to do it. Under the current deficit reduction problems we have, I don't think the State——

Mr. KOPETSKI. So your testimony is we should not use Pittman-Robertson funds for that purpose?

Mr. BEARD. I don't think we should be doing that now. I think we should be spending the money to finance the medical health program.

Mr. KOPETSKI. But isn't this money that is generated from the sportsmen and women?

Mr. BEARD. It certainly is, and it ought to go into paying some of the costs that is incurred by society because of the sale of those deadly products.

Mr. KOPETSKI. But you are saying that money should no longer go into shooting ranges?

Mr. BEARD. I am saying that——

Mr. KOPETSKI. That is a yes or no.

Mr. BEARD [continuing]. A portion of it ought not to, yes.

Mr. KOPETSKI. Should some of it go into shooting ranges, yes or no?

Mr. BEARD. I think some of it could go into shooting ranges, but most of it should not, absolutely not.

Mr. KOPETSKI. OK. I don't have any further questions.

Do you have some questions?

Mr. HANCOCK. Yes, I am interested in your organization, Stop Gun Violence. I don't think anybody could disagree with the name of it, and in fact there are many of us who have been working toward that goal, including the NRA. For many, many years before your organization existed the NRA has had an educational program. They have been developing the program for quite some time.

But evidently your solution to stopping gun violence is to disarm the American public, is that correct?

Mr. BEARD. Yes, sir, that is correct. We believe there ought to be a ban on the manufacture and sale of handguns and paramilitary style assault weapons except for police, military, licensed security guards and gun clubs where the guns are kept locked up on the property of the club.

Mr. HANCOCK. Let's visualize that situation. Let's say we were able to legally ban handgun manufacturing in this country. Do you not think there would be handguns available?

Mr. BEARD. No, I don't believe handguns would not be available. We know there are some 200 million firearms out there now, and many of those——

Mr. HANCOCK. Let's take it one step further, let's say we could find all those handguns and confiscate them. We are talking pie in the sky.

Mr. BEARD. We cannot under the Constitution.

Mr. HANCOCK. Theoretically, let's say there was some way to do that. How long do you think it would be before handguns would be available again even if we confiscated them?

Mr. BEARD. I don't think given the experience of the rest of the countries of the world that they would ever be available.

Mr. HANCOCK. You are aware of what happened in Germany when they confiscated the handguns? I mean, there were still handguns around.

Mr. BEARD. Absolutely, no matter what kind of legislation we are going to have there is still going to be handguns available. The question is whether we make them so readily available.

Mr. HANCOCK. All right. Here again, they are readily available because that is a privilege that we happen to have in this country, as far as I am concerned. Nobody is going to argue with you at all on stopping gun violence.

As I said earlier, that is what we are working on. I also would like to ask you about your estimate which puts the cost to the health care system from treating victims of gun violence at $23 million a year.

Does this estimate come from a study?

Mr. BEARD. That comes from a study done by Dr. Gaien Wintemule at the University of California at Davis in a series of conferences that I have attended around the country where Davis, representatives from the Centers for Disease Control and other social science and political health——

Mr. HANCOCK. Do you have the documentation on that?

Mr. BEARD. I have a document on it, and I would be glad to supply it to the committee.

Mr. HANCOCK. Would you supply that. We would be glad to make it a part of the record.

Mr. BEARD. Absolutely.

[The information follows:]

The following is excerpted from "Shooting in the Dark: Estimating the Cost of Firearm Injuries" by Wendy Max and Dorothy Price, Institute for Health and Aging, School of Nursing, University of California, San Francisco.

Results

Costs are presented by class of injury, age, gender, and type of cost.

Incidence

In 1985, firearms caused 31,556 fatalities; 65,127 hospitalizations; and 171,000 injuries that required some outpatient medical care or resulted in at least one day lost from the usual activity (Table 1). That is, for every fatal firearm injury, there are an additional two injuries requiring hospitalization, and an additional 5.4 injuries not severe enough to be hospitalized. Four-fifths of injured persons were male, and young adults aged 25 to 44 are most often injured.

Type of Cost

Firearm injuries resulted in at total social cost of $14.4 billion in 1985 (Table 2). The largest proportion of the cost was for fatal injuries: $12.2 billion (84 percent), and most of this represents the value of productivity losses from premature death. Hospitalized injuries account for $2 billion or 15 percent of the total. For this group, two-thirds of the cost is lost productivity resulting from illness and disability, and the remaining one-third is direct cost, primarily for hospitalization. The cost associated with the nonhospitalized injuries represents only 1 percent of the total cost, and is divided almost equally between direct costs and morbidity costs.

The most severe injuries drive the economic impact of firearm injuries, as shown in Figure 1. Though fatal injuries represent only 12 percent of the total number of injuries, they account for 84 percent of the social costs. Conversely, two-thirds of firearm injuries are not severe enough to require hospitalization, and they result in only 1 percent of the total cost. On a per person basis, fatal injuries are most costly considering both the direct and indirect costs - $374,000 per injured person versus $33,000 and $500 per person respectively for hospitalized and nonhospitalized injuries. The direct costs per injured person are greatest for hospitalized injuries ($12,000), followed by fatalities ($2900) and nonhospitalized ($200).

Direct Cost Components

Direct costs are presented in further detail by type of expenditure in Table 3. For fatal injuries, four-fifths of the direct costs represent the cost of hospitalization. These persons also incur costs for emergency room services and ambulance transportation as well as health insurance. The direct costs for hospitalized persons are primarily for hospitalization and rehospitalization (84 percent). However, they also incur costs for physicians and other professional services (9 percent) and nonmedical items. Two-thirds of the direct costs for nonhospitalized firearm-injured persons are accounted for by physicians services and emergency room visits.

Gender and Age

The fact that males are much more likely to be injured by firearms than females is reflected in the cost (see Table 4). $12.3 billion (86 percent) of the total $14.4 billion is accounted for by males. Most of this costs ($10.6 billion) is due to male fatalities. Young adults incur most of these costs: over half of the total cost is for injured persons aged 25 to 44. Within each class of injury males specifically, and young adults generally, account for most of the costs.

Per person costs for males ($57,000) are 1.4 times as great as for females ($40,000). Costs per death increased with age up to 25-44 years for males and females. This results from both the lifetime pattern of earnings and the impact of discounting. The lack of clear patterns in the per person costs by age for hospitalized and nonhospitalized injuries reflects the limitations of the data and small sample sizes for the nonhospitalized estimates.

Years of Potential Life Lost

Firearm injuries resulted in a loss of 1.3 million years of potential life lost in 1985 (Table 5). Most of these losses are attributable t premature death (1.16 million). However, persons hospitalized due to their injuries lost 187,000 potentially productive years, and even persons not hospitalized lost over 1,300 years.

Fatally injured males lost an average of 34.6 years each, and females lost 41.0 years, reflecting the fact that typical victims are relatively young. The per person losses for hospitalized males (2.2 years) and females (7.4 years) indicate the substantial disability that a firearm injury can cause.

1990 Costs

1985 estimates were updated to 1990 taking into account both inflationary and real changes. Direct costs were adjusted using the percentage change in personal health care expenditures between 1985 and 1990 (U.S. HCFA 1991). These data incorporate inflation in the medical care market as well as the effect of changing demographics and patterns of health care utilization. Cost components were adjusted separately using personal health care expenditures on hospital care, physician services, other professional services, drugs, other personal health care, and program administration and net cost of insurance. For indirect costs, inflation and real change were estimated separately. The change in hourly compensation in the business sector (U.S. Department of Labor 1989) was used for inflation, the change in the number of episodes of persons injured was used to reflect real change for morbidity (U.S. National Center for Health Statistics 1986), and the change in firearm injury deaths (U.S. National Center for Health Statistics, 1992) was used to reflect real change for mortality.

The 1990 costs are shown in Table 6. The total cost of firearm injuries is estimated to be $20,4 billion, including $17.5 billion for fatalities, $2.8 billion for hospitalized injuries, and $.1 billion for nonhospitalized injuries. That is, taking into account changes in the number of injuries, patterns of healthcare utilization, and inflation, the cost of firearm injuries will increase 42 percent in the five year period. Direct costs show the greatest increase over that period - 55 percent.

Table 1. Incidence of Firearm Injuries by Age, Gender, and Class of Injury, 1985

Age	TOTAL	Fatal*	Hosp	Nonhosp
Both	267,683	31,556	65,127	171,000
0–4	303	104	199	0
5–14	24,274	590	2,684	21,000
15–24	60,299	6,879	28,420	25,000
25–44	164,158	13,140	26,018	125,000
45–64	12,445	6,398	6,047	0
65+	6,204	4,445	1,759	0
Male	216,083	26,366	56,717	133,000
0–4	132	61	71	0
5–14	19,650	464	2,186	17,000
15–24	52,350	5,894	25,456	21,000
25–44	128,503	10,831	22,672	95,000
45–64	10,187	5,217	4,970	0
65+	5,261	3,899	1,362	0
Female	51,600	5,190	8,410	38,000
0–4	171	43	128	0
5–14	4,624	126	498	4,000
15–24	7,949	985	2,964	4,000
25–44	35,655	2,309	3,346	30,000
45–64	2,258	1,181	1,077	0
65+	943	546	397	0

*Excludes 1,030 deaths occurring in later years due to 1985 injuries.
Source: Rice, MacKenzie, and Associates, 1989

Table 2. Cost of Firearm Injury by Type of Cost and Class of Injury 1985

	TOTAL	Fatalities*	Hosp.	Nonhosp.
Cost (millions)				
TOTAL	$14,410	$12,172	$2,160	$78
Direct	911	92	784	36
Morbidity	1,418	0	1,376	43
Mortality**	12,080	12,080	0	0
Per Person Cost				
TOTAL	$53,831	$373,520	$33,159	$458
Direct	3,405	2,813	12,038	209
Morbidity	5,298	0	21,122	250
Mortality	45,127	370,706	0	0
Incidence	267,685	31,556	65,129	171,000

*Based on 32,586 deaths, including 1,030 deaths in later years due to 1985 injuries
**Discounted at 6 percent

Table 3. Direct Cost of Firearm Injuries by Type of Expenditure, 1985 ($thousands)

	TOTAL	Fatal*	Hosp	Nonhosp
TOTAL DIRECT	$911,411	$91,676	$784,002	$35,733
MEDICAL	$863,586	$88,150	$741,170	$34,266
Hospitalization	455,157	74,678	380,479	0
Physicians	54,423	0	39,197	15,226
ER Visits	18,404	9,988	0	8,416
Rehosp.	279,546	0	279,546	0
Medications	6,078	0	2,658	3,420
PT	18,114	0	18,114	0
Ambulance	9,335	3,484	5,339	512
Attendant	11,508	0	11,508	0
Other Expenses	11,021	0	4,329	6,692
NONMEDICAL	$47,825	$3,526	$42,832	$1,467
Home Mod	10,020	0	10,020	0
Voc Rehab	3,723	0	3,626	97
Health Ins.	34,082	3,526	29,186	1,370

*Includes 1,030 deaths in later years from 1985 injuries

Table 4. Cost of Firearm Injuries by Age, Gender, and Class of Injury, 1985

	Total ($ thousands)				Per Injured Person			
	TOTAL	Fatal*	Hosp	Nonhosp	TOTAL per Person	Per Death**	Per Hosp. Injury	Per Nonhosp Injury
Both	**$14,409,544**	**$12,171,513**	**$2,159,631**	**$78,400**	**$53,831**	**$373,520**	**$33,160**	**$458**
0–4	32,842	22,924	9,918	0	108,389	220,423	49,839	0
5–14	293,403	208,556	80,989	3,858	12,087	270,852	30,175	184
15–24	4,204,064	3,465,337	731,764	6,963	69,720	471,603	25,748	279
25–44	7,837,865	6,820,229	950,057	67,579	47,746	507,646	36,515	541
45–64	1,848,283	1,546,806	301,477	0	148,516	240,299	49,856	0
65+	193,087	107,661	85,426	0	31,123	23,962	48,565	0
Male	**$12,328,116**	**$10,567,262**	**$1,694,188**	**$66,666**	**$57,053**	**$387,221**	**$29,871**	**$501**
0–4	19,556	14,502	5,054	0	148,152	237,738	71,183	0
5–14	240,553	171,988	65,372	3,193	12,242	267,062	29,905	188
15–24	3,668,595	3,057,966	604,666	5,963	70,078	486,937	23,753	284
25–44	6,740,014	5,921,904	760,600	57,510	52,450	533,409	33,548	605
45–64	1,534,544	1,314,396	220,148	0	150,637	250,075	44,295	0
65+	124,854	86,506	38,348	0	23,732	21,917	28,156	0
Female	**$2,081,428**	**$1,604,251**	**$465,443**	**$11,734**	**$40,338**	**$309,104**	**$55,344**	**$309**
0–4	13,286	8,422	4,864	0	77,696	195,860	38,000	0
5–14	52,850	36,568	15,617	665	11,429	290,222	31,359	166
15–24	535,469	407,371	127,098	1,000	67,363	381,434	42,881	250
25–44	1,097,851	898,325	189,457	10,069	30,791	385,051	56,622	336
45–64	313,739	232,410	81,329	0	138,946	196,791	75,514	0
65+	68,233	21,155	47,078	0	72,357	38,745	118,584	0

*Discounted at 6 percent
**Based on 32,586 deaths, including 1,030 deaths in later years from injuries occurring in 1985

Table 5. Years of Potential Life Lost Due to Firearm Injuries, 1985

	Total	Males	Females
TOTAL	1,350,467	1,071,013	279,454
Morbidity – Hospitalized			
Total	187,117	124,853	62,264
Per hospitalized person	2.87	2.20	7.40
Morbidity – Nonhospitalized			
Total	1,350	1,160	190
Per nonhospitalized person	0.01	0.01	0.00
Mortality*			
Total	1,162,000	945,000	217,000
Per death	35.7	34.6	41.0

*Includes 1,030 deaths that occurred in later years due to 1985 injuries

Table 6. Cost of Firearm Injuries by Type of Cost and Class of Injury, 1990 (millions of dollars)

	TOTAL	Fatal	Hosp	Nonhosp	% Increase Over 1985
TOTAL	$20,417	$17,502	$2,806	$109	42
Direct	1,410	141	1,209	60	55
Morbidity	1,647	0	1,597	50	16
Mortality*	17,361	17,361	0	0	44

*Discounted at 6 percent

Mr. HANCOCK. Because that $23 billion is a pretty big figure, it is far and above what most of the other witnesses have testified to.

Mr. BEARD. Yes. As you know, part of the difference is what do you count, so whether you count the number of man-hours or person hours that are lost from work and all kinds of other things, but that is why these estimates are so varied because what you count as the total costs.

Mr. HANCOCK. Well, let me ask you another question, then. Do you see any rational reason for people to own a handgun?

Mr. BEARD. Right now, given the system we have, I think most people own handguns because they are frightened of the violence, and there is a feeling that somehow they can protect themselves against the vagaries of the 20th century by owning a handgun.

I think that is a totally irrational belief and that every social science study that I have seen shows that it doesn't work. We have given 25 years over to the gun culture and look what has happened. We have doubled the number of firearms in our society, we have raised the death level, the homicide rate by 60 percent.

The gun culture, we have tried it for 25 years, it did not work. It has brought us to this total failure that we have now, and that is why you get the majority of the population saying let's just ban all of those weapons because Americans are fed up with the violence, the destruction of our society because of the last 25 years of making it easy for anybody to buy firearms.

Mr. HANCOCK. Well, I disagree that a majority of the population says to ban weapons.

Mr. BEARD. There is a Harris poll to that subject, I would be glad to submit that for the record, the entire poll, if you would like to have it.

Mr. HANCOCK. Here again, I would like to see how the questions were asked. If you asked, "Would you ban a handgun for the individual who wants to protect his life?" most people would say no.

If you were to ask, "Do you want to ban handguns to keep people from going out and shooting people?" they would say yes. So I would like to see the questions and how they were presented.

Mr. BEARD. I would be glad to submit that for the record.

Mr. HANCOCK. You say that these people use these weapons and it doesn't prevent crime. Is it irrational an individual to own a gun? The other day, about a mile from my home, a liquor store owner used a handgun in protecting his life; he certainly didn't buy it because he wanted to perform a criminal act or shoot somebody.

What would you recommend if in fact a law abiding citizen doesn't have any way to protect his life? What is he going to do?

Mr. BEARD. Well, first of all, at the same time that your constituent was protecting his life, there were some 60 other people who were being either killed or injured with guns that day, not in any criminal activity.

I mean, we have got to look at the overall gun violence problem. You know what has happened here in the District of Columbia just in the last 2 weeks because of guns.

Mr. HANCOCK. There may be 60 throughout the country, but this was just in one little town, and he was the only victim that I'm aware of.

Mr. BEARD. But you have to look at what happens to the entire country from this issue and not from the perspective of one single individual. Certainly there are going to be individuals who use firearms to protect themselves.

There are better ways to protect yourself, particularly for liquor store owners or anyone else, and any police department in the country will tell a store owner 100 better ways to protect him or herself than carrying a firearm.

There are all kinds of programs that were available to a small business for protection that involve not using firearms.

Mr. HANCOCK. Are you aware of what my background was before I came to the Congress?

Mr. BEARD. I am not.

Mr. HANCOCK. Well, I disagree strongly with your statement that there are 100 better ways to protect yourself from an armed criminal than being armed also. If that were true, then I am sure that our law enforcement officers would use 10 of them.

I frankly can't think of any better way to protect yourself from an armed criminal unless you are better armed than he is. If he has a pistol and you have a shotgun, then you are better armed because he will probably miss and you won't miss with a shotgun.

Mr. BEARD. Mr. Hancock, I suggest to you that is why we are in the mess we are in because some people believe that kind of nonsense. We are not——

Mr. HANCOCK. Beg your pardon?

Mr. BEARD. I think that is why we are in the mess we are in because people believe the nonsense that buying a gun is going to protect them, and it does not. If people carrying guns made for a safe society, America would be the safest society in the world. We are not. We are one of the least safe societies.

As I pointed out to you, a black man in Harlem has a lower life expectancy than a man living in Bangladesh because of the presence of guns in our society.

Mr. HANCOCK. And that is the only reason?

Mr. BEARD. No, it is not the only reason, absolutely not, no, I am not saying that.

Mr. HANCOCK. That is what you are saying.

Mr. BEARD. No, I am not. I am saying that is one of the major factors.

Mr. HANCOCK. Let's blame some of the other reasons that that occurred. Let's talk about the breakdown of the family; let's talk about the advent of the drugs; let's talk about what is happening in our schools.

Those problems were not brought on because people own handguns.

Mr. BEARD. That is correct. You have racism and sexism and economic deprivation, you have all of those problems.

Mr. HANCOCK. Getting rid of the handguns isn't going to solve the problem.

Mr. BEARD. It is not going to solve those problems, but we are not going to be able to deal with those problems until we first deal with the instrument of violence in our society and the instrument of violence is firearms in America. We have more guns than any

other country in the world, we have more death than any other country in the world.

Mr. HANCOCK. I want to get back to this idea that a tax subsidizes the people that you tax. I'm not sure I understand. I don't know how by taxing the firearm industry that you are subsidizing the firearm industry. I guess you could say you tax gasoline so you are subsidizing the gasoline industry.

In effect that would be true. The tax revenues pay for highways. Is that what you are getting at?

Mr. BEARD. First of all, the tax is not on the industry, the tax is on the people who buy the products, and the money then goes back to the States and it does not go back on the basis of where it came from, it goes back on a much more complicated formula, as Mr. Gardiner pointed out earlier.

We are using that money for the wrong purposes now in our society. It made sense in the 1930s, 1940s, and 1950s, it doesn't make sense in the 1980s and 1990s.

Mr. KOPETSKI. Mr. Reynolds may inquire.

Mr. REYNOLDS. Thank you, Mr. Kopetski and Mr. Hancock.

I first of all wanted to say that I am very much, being a person who has sponsored this notion of taxing handguns, I am very much in favor of this. I understand that there is opposition for this. Mr. Gardiner, could you tell me the names of some organizations on the south side of Chicago that the National Rifle Association has helped in education as far as guns are concerned and the kind of money you have spent in some of the poor high schools that have all the violence going on in the south side?

Mr. GARDINER. Mr. Reynolds, we would love to do programs like that. Unfortunately the city of Chicago bans most—all handguns and makes other firearms so difficult to acquire that we would be engaging in a conspiracy if we were involved in trying to educate people.

We would be very glad and hope you would work with us to try to repeal that law so we could bring education to the city of Chicago. We would very much like to do that.

Mr. REYNOLDS. So since you guys have been banned by the city of Chicago educating about guns, you haven't found it a good idea to get involved in the system, school system in Chicago, in the south side in any kind of education?

Mr. GARDINER. We would very much like to do that and would be glad to work with your good offices to accomplish at least the safety education in the schools, and if you could do something to help us get rid of the handgun ban in the city, we would like to get involved in training as well.

Mr. REYNOLDS. So to date there is not one dime at all?

Mr. GARDINER. I believe, in fact there is a program, although unfortunately I can't give you the details because I am not involved directly in it.

Mr. REYNOLDS. I see. Let me just say this to you and your organization: I resent your members coming to my town hall meetings and disrupting them. I don't like it, and I want it to stop. There is no education at the National Rifle Association is doing in the south side of Chicago. You have never done any education on the south side of Chicago, even before the ban was there, you didn't.

Other companies, other organizations who don't have the same kind of violence that is going on as a result of firearms in our city, are involved in the school system because they feel it is necessary to help people who are poor and who need educational opportunities.

I find it no excuse whatsoever that the city of Chicago has banned guns and therefore you guys aren't involved in education or any kind of activity involved as far as the education in the city of Chicago is concerned.

Mr. GARDINER. Well, Mr. Reynolds, do I have your agreement, then, that you will help us get our education programs into the city of Chicago schools? I will be glad to do that.

We have an excellent safety program for small children called Eddie Eagle, and if we could use—if we could work with you to get it into the school system, I guarantee you that we will do that.

Mr. REYNOLDS. I will not tell you that I will work with you until I am convinced that you are sincere about doing it, and until I am sincere about it, I won't give you that commitment.

Mr. GARDINER. Will you tell me what it would take for you to be convinced that I am sincere about it?

Mr. REYNOLDS. First of all, I would like to see what your track record is in other poor areas across the country where you don't have a ban, like Los Angeles.

Mr. GARDINER. Where we don't have what?

Mr. REYNOLDS. Where you don't have the same kind of difficulties in the school systems like you claim you have in Chicago. What other cities, what major urban area, like Philadelphia, for example, Atlanta, or Los Angeles, or Boston where you have—you can give me an example of a program——

Mr. GARDINER. I will be very glad. I can't give you that on the spot because that is not my area of responsibility, but I will be more than glad if we can set up a meeting with your office to bring you that information.

Mr. REYNOLDS. Perhaps the reason you can't give me it is because you don't have any.

Mr. GARDINER. No, we have put the Eddie Eagle program in thousands of schools around the country, and I believe that the numbers now of students who have been exposed to it is in the millions. I would be very glad——

Mr. REYNOLDS. But you can't tell me of any program that you know of in any urban areas.

Mr. GARDINER. That I personally know of, no, I said I am not in that area, I am not involved with the educational programs, but I will be very pleased if we can set up a meeting in your office to bring you that information at your convenience.

Mr. REYNOLDS. Thank you.

Mr. Beard, I just want to say that I really applaud your efforts and the work that your organization is doing.

Ms. Yosko, I think that people need to see that trauma center, that rehab center that you have just opened on the south side of Chicago. They need to see it firsthand and stop talking about how this is an infringement and start looking at the real tragedy that poor people have to deal with in their lives when it comes to handgun violence.

Nobody is suggesting any solution as far as I am concerned to these problems in our society as it relates to guns. They are just talking about things that really don't make it better for people's lives, and you can count on me for as long as I am here to fight organizations that destroy people across this country, and I will take no step backward, no matter who agrees with it.

Thank you very much indeed.

Mr. KOPETSKI. Thank you, Mr. Reynolds. I am certain that everybody in this room has a strong commitment to eliminating violence in our society as well as providing decent affordable and readily available health care to all Americans regardless of whether they live in an urban area or rural areas as well.

We have some tough problems in our society, we recognize them, we are all searching together for the solution. We may not agree always on the means to get there, but I am confident that we have the same goals in mind. We do have a vote.

I would like to recess the committee and then we will come back to the final panel.

[Recessed for a vote].

Mr. KOPETSKI. The committee will return to order. We have our final panel for the evening, Carol Beasley, Ms. Beasley from the Partnership for Organ Donation, Inc., of Boston, Mass.; Pamela Davis, president and CEO of Nonprofits' Insurance Alliance of California; and Donald Udstuen, chief operating officer, Illinois State Medical Insurance Services, Inc., accompanied by Lawrence Smarr, the executive director.

Welcome Ms. Beasley.

STATEMENT OF CAROL L. BEASELY, MANAGING DIRECTOR, PARTNERSHIP FOR ORGAN DONATION, INC., BOSTON, MASS.

Ms. BEASLEY. Thank you, Mr. Chairman, members of the committee, thank you for including my written statement in the record.

My name is Carol Beasley, and I am the managing director of the Partnership for Organ Donation. I will use the next few minutes to summarize the key points of my written statement which comments on proposed legislation by Congressman Durbin to include educational materials on organ donation in tax refunds.

The partnership is a Boston-based nonprofit organization dedicated to saving and improving lives by closing the gap between the number of organ transplants that are possible and the number of organ donations that actually occur.

We believe an effective campaign to educate the public on organ donation must be based on a realistic understanding of the attitudes and behavior of the American public. Recently the Partnership for Organ Donation, the Harvard School of Public Health, and 17 organ procurement organizations around the country collaborated on the largest Gallup survey ever conducted about organ donation.

The survey reached over 6,000 Americans and contains the following highlights: First, the American public strongly supports organ donation. Eighty-five percent of the American public supports the donation of organs for transplant and 69 percent say they are very likely or somewhat likely to want their organs donated after death.

Second, many Americans misunderstand the donation process. Despite widespread support there are some serious gaps in the public's understanding about how organ donation works. Most Americans, 79 percent, believe incorrectly that a person must carry a signed donor card in order to become a organ donor. In fact, regardless of the existence of a donor card, permission is required from the next of kin, but 42 percent of the public do not realize this.

Family communication, third, can lead to more organ donation. The Gallup survey shows that family communication is a crucial link in solving the shortage of life-saving organs for transplantation. An overwhelming majority, 93 percent, said they would be willing to donate a deceased family member's organs if he or she had expressed this wish prior to death, but less than half of those polled said they would be likely to donate a family member's organs if this discussion had not taken place.

The benefits of family communication held across all age, education, and ethnic groups.

Four, minorities have distinct educational needs regarding organ donation. Minority patients make up about a third of the list of patients waiting for transplant. These patients wait longer for transplant for a variety of reasons, including the fact that medically optimal organ matches are harder to achieve across ethnic groups than within them.

Despite the higher level of need, support for organ donation in African-American and Hispanic communities is substantially lower than it is among non-Hispanic whites. Fewer blacks and Hispanics say they would be likely to want their organs donated after death, and in general these groups express higher levels of concern about possible negative aspects of donation.

These findings imply different sets of educational needs among different parts of the population. The issues relating to minority attitudes and actions toward donation are complex. It is clear that we will not solve the donor shortage without the participation of minorities, and we will not gain the participation of minorities without first identifying and resolving the issues unique to minority communities.

We need to understand how the negative perceptions within minority communities were formed and then design specific educational programs addressing these concerns and issues.

In summary, we strongly support the recommendation in the legislation proposed by Mr. Durbin to focus on family communication as a primary objective and further recommend utilizing the organ donor card as an adjunct and stimulus to family communication, not as an end in itself.

We also wish to emphasize the large stake that minority communities have in the success of the transplant system. Special focus must be put on including educational messages that address the specific concerns of minority groups to encourage greater minority support for organ donation and participation in the system.

I would like to conclude my remarks by commending Congressman Durbin for sponsoring this legislation. The Partnership for Organ Donation hopes it is speedily approved by the House and Senate and is enacted into law as soon as possible.

I have also brought with me copies of the Gallup survey for the members of the committee which I will leave with the committee staff at the end of this panel.

Thank you for this opportunity to speak before the subcommittee today.

Mr. KOPETSKI. Thank you, Ms. Beasley, appreciate your brevity.

[The prepared statement follows. A copy of the survey entitled "The American Public's Attitudes Toward Organ Donation and Transportation," is being retained in the committee files:]

Testimony of

Carol L. Beasley

Managing Director,
The Partnership for Organ Donation

Good afternoon Mr. Chairman, committee members and staff. Thank you for this opportunity to speak before the House Ways and Means Committee.

My name is Carol Beasley, and I am the Managing Director of The Partnership for Organ Donation. The Partnership is a Boston-based nonprofit organization dedicated to saving and improving lives by closing the gap between the number of organ transplants that are possible and the number of organ donations that actually occur. Our focus encompasses both professional education and public education to improve donation. For the past three years we have conducted research and educational interventions in organ procurement organizations across the country to increase organ donation.

I will be commenting today on the proposed legislation put forward by Representative Richard Durbin of Illinois to include educational material on organ donation in tax refunds mailed to 80 million Americans each year. Our recommendations will focus on how this proposal can best achieve its potential to increase organ donation through effective education of the American public.

In the Partnership's view, there are three things that will lead to increased organ donation:

1) Effective public education
2) Effective professional education
3) An environment of trust, based on a fair and equitable donation and transplantation system

These three elements are necessary and interdependent; the lack of any one of these will limit the benefits of the other two.

PUBLIC EDUCATION

We believe an effective campaign to educate the public on organ donation must be based on a realistic understanding of the attitudes and behavior of the American public. Recently, The Partnership for Organ Donation, the Harvard School of Public Health, and seventeen organ procurement organizations around the country collaborated on the largest Gallup Survey ever conducted about organ donation. The survey reached over 6000 Americans, and contains the following highlights:

The American public strongly supports organ donation:
Eighty-five percent of the American public supports the donation of organs for transplant, and 69 percent say they are very likely or somewhat likely to want their organs donated after death.

This finding shows that awareness and support for donation are already extremely high. Therefore, public education campaigns do not need to focus on building awareness, but can focus on encouraging Americans to act upon the awareness and support that already exists for donation.

Many Americans misunderstand the donation process:
Despite widespread support, there are some serious gaps in the public's understanding about how organ donation works. Most Americans, 79 percent, believe incorrectly, that a person must carry a signed donor card in order to become an organ donor. In fact, regardless of the existence of a donor card, permission is required from the next of kin, but 42 percent of the public did not realize this.

In implementing the proposed legislation, serious thought must be given to the role of the donor card. As previously implemented donor cards have done little to bring about donation, and may have inadvertently contributed to misunderstanding about the donation process. Donor cards must be used to encourage and facilitate family discussion.

Family communication can lead to more organ donation:
The Gallup survey shows that family communication is a crucial link in solving the shortage of lifesaving organs for transplantation. An overwhelming majority -- 93 percent -- said they would be willing to donate a deceased family member's organs if he or she had expressed this wish prior to death. But, less than half of those polled said they would be likely to donate a family member's organs if this discussion had not taken place. The benefits of family communication held across all age, education, and ethnic groups.

Therefore, our recommendation to the committee is that the message contained in the proposed educational flyer stresses family communication and helps to empower families to undertake this type of communication successfully. If donor cards are included, they must be dealt with in the context of family communication.

Minorities have different educational needs than whites regarding organ donation:
The educational challenge of organ donation is a large one, and the educational needs of various groups are not identical. I'd like to speak particularly about minority concerns about organ donation. As you may know, minorities and specifically African-Americans and Hispanics, are disproportionately represented on the list of individuals waiting for organ transplant. Minority patients make up about a third of the list of patients waiting for transplant. These patients wait longer for transplant for a variety of reasons, including the fact that medically optimal organ matches are harder to achieve across ethnic groups than within them.

Despite the higher level of need, support for organ donation in the African American and Hispanic communities is substantially lower than it is among whites. Fewer blacks and Hispanics say they would be likely to want their organs donated after death, and in general these groups express higher levels of concern about possible negative aspects of donation. These findings imply different sets of educational needs among different parts of the population. Some examples include the following:

- African-Americans and Hispanics are more concerned than whites about possible disfigurement of the body after organ donation, and about the need to be buried with all of the body's parts intact.

- Minorities are far more likely to consider transplantation to be an experimental medical procedure, with 54 percent of African-Americans and 46 percent of Hispanics viewing it as experimental, versus 37 percent of whites.

- And, while 19 percent of whites incorrectly believe that a brain dead person -- a potential organ donor -- can recover, 33 percent of African Americans and 29 percent of Hispanics hold this belief.

The issues relating to minority attitudes and actions toward donation are complex. It is clear that we will not solve the donor shortage without the participation of minorities, and we will not gain the participation of minorities without first identifying and resolving the issues unique to minority communities. We need to understand how the negative

perceptions within minority communities were formed and then design specific educational programs addressing these concerns and issues.

Our recommendations to this committee are first, to seek input from experts on minority issues on organ donation in creating the educational material to be sent with tax refunds. Second, on any educational material to be distributed, we believe it is important to provide access to further information on donation issues, so that respondents can seek educational materials that relate to their specific concerns.

PROFESSIONAL EDUCATION

As mentioned earlier, public education alone will not suffice to solve the organ donor shortage. Public education must be complemented by professional education. All families are entitled to a donation process in the hospital that is sensitive to their needs. Currently there are few standards and guidelines for implementation of an effective donation process. There is no guarantee currently that families will be dealt with supportively in the hospital setting at the time a relative has died and donation is a possibility.

For three years The Partnership has collaborated with organ procurement organizations across the country to improve the donation process offered to families within the hospital. We have found that donation can double if steps are taken to identify every potential donor and to offer families a systematic and sensitive process.

Our research shows that currently only one-third of all potential donors actually donate organs. In one third of potential donor situations, the family is never offered the option of donation, and in the remaining third of cases the family of the deceased denies consent to donation.

Intensive professional education efforts -- tailored to the individual needs of hospitals -- can close the gap between the potential and actual number of organ donors. By implementing a donation process in which all potential donors are identified and all families are provided with a sensitive request, organ donation can increase significantly.

In order for public educational efforts to succeed, hospital staff must cooperate in identifying potential donors and offering each family the option of donation in an appropriate and sensitive way.

EQUITY OF THE SYSTEM

Most Americans are well aware that organ transplants are constrained by the scarcity of donor organs. More than two-thirds believe that most people who need transplants do not receive them. There are also severe concerns about the equity of the system -- concerns that can only be exacerbated by much of the recent news coverage surrounding Governor Casey's heart-liver transplant, and recently published reports of high and widely varying costs of organ procurement. A recent report by the General Accounting Office (ORGAN TRANSPLANTS: Increased Effort Needed to Boost Supply and Ensure Equitable Distribution of Organs, GAO/HRD-93-56) points out a number of concerns about the performance of the current organ donation and transplant system.

Concerns about equity are widespread among the public. Twenty-eight percent of the public believes that racial discrimination prevents minority patients from receiving the organ transplants they need. This concern is higher among minority respondents -- 38 percent of black respondents felt this way as did 37 percent of Hispanic respondents.

Even more prevalent is concern about economic discrimination in allocation of organs. Fifty-eight percent of respondents disagreed with this statement: "Given equal need, a poor person has a good a chance as a rich person of getting an organ transplant." Concerns about economic discrimination cut across economic and ethnic lines. In fact, higher-income respondents were more likely to perceive the existence of economic discrimination than lower income respondents.

Another strong indication of concern about equitable access to organ transplants is the widespread belief that organs can be bought and sold today in the United States. Despite the illegality of buying and selling organs, and the lack of any evidence for a black market in organs, 34 percent of the public believes that organs for transplant can be bought and sold on the black market in the U.S. An additional 25 percent are unsure whether this is so.

Questions about the fairness of the transplant system must be promptly and stringently addressed; otherwise no amount of public education can restore public trust in the system.

CONCLUSION

I would like to conclude my remarks by commending Representative Durbin for sponsoring this legislation. The Partnership for Organ Donation hopes it is speedily approved by the House and Senate and is enacted into law as soon as possible. We also stand ready to provide any input and guidance desired by this committee and others working to ensure effective implementation of this bill. With more than 30,000 Americans waiting to receive a lifesaving or life enhancing organ, this legislation could not be more needed or timely.

REFERENCES:

ORGAN TRANSPLANTS: Increased Effort Needed to Boost Supply and Ensure Equitable Distribution of Organs, United States General Accounting Office Report to Congressional Committees, GAO/HRD-93-56, April 1993

The Gallup Organization, Inc., "The American Public's Attitudes Toward Organ Donation and Transplantation," conducted for The Partnership for Organ Donation, Boston, MA, February 1993

"Solving the Organ Donor Shortage," The Partnership for Organ Donation, Boston, MA, 1991

STATEMENT OF PAMELA E. DAVIS, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NONPROFITS' INSURANCE ALLIANCE OF CALIFORNIA

Mr. KOPETSKI. Ms. Davis, welcome to the committee.

Ms. DAVIS. Thank you. Mr. Chairman, members of the committee. I am Pamela Davis, I am president of the Nonprofits' Insurance Alliance of California. We are also known as NIAC.

I come here today to ask you to clarify under 501(m) NIAC's status as an organization exempt from tax under section 501(c)(3). NIAC is a liability risk pool for charitable 501(c)(3) tax exempt nonprofits in California. We began operations in late 1989 with $1.3 million in funds from six foundations.

We have nearly 800 member insureds and expect to have a total annual premium volume of $5.5 million in 1993, and we are growing at the rate of one new member every day.

NIAC is strikingly different from commercial insurers in a number of ways. First, we are member controlled. NIAC is a nonprofit public benefit corporation, which is owned and governed by its charitable members. Our board of directors is elected annually by the membership. Second, 100 percent of NIAC's implementation costs and original capital, funds totaling $1.6 million, were provided by independent private and community foundations. That is, charitable organizations that are not beneficiaries of NIAC. Largely because of our undetermined tax status, our capital was provided in the form of subordinated low interest loans instead of grants. Our funders include the Ford Foundation, and the Packard Foundation, they also include the publicly supported San Francisco Foundation and the Marin Community Foundation.

Third, all financial benefits of NIAC accrue to its charitable members, and NIAC's assets are irrevocably dedicated to charitable purposes. To operate prudently, NIAC needs additional capital to meet the needs of our growing membership. Because NIAC's organizational structure is so unlike commercial insurers, we cannot attract private capital. Tax exempt status under 501(c)(3) would enable us to access the only source of permanent capital available to us, grants from private and community foundations.

NIAC was created because commercial insurance carriers were not supplying adequate or affordable coverage to nonprofits.

Written testimony provided to this committee by the County of Alameda elaborates on that point. During the mid-1980s the provision of social services in California was severely hampered. Charitable nonprofits could not find affordable liability insurance, and many had their policies cancelled and nonrenewed.

A study funded by the Ford Foundation found that charitable nonprofits are seriously disadvantaged insurance consumers, particularly during periods of low capacity in the insurance industry. The economics of commercial insurance all but guarantee that the periods of low availability and high prices will periodically replace the more affordable prices that currently prevail.

All of NIAC's initial capital was provided in the form of highly subordinated 2 percent loans. We pass the benefits of our subsidized capital on as savings to our members. Even in the present climate of moderate insurance prices, NIAC is providing liability insurance coverages to those formerly unable to find coverage.

From what our members tell us on their applications to NIAC, we are providing those coverages at an average of 30 percent below commercial rates, and we expect to save our members $2 million in 1993 alone.

Let me tell you a little about our members. Most of our members are quite small with a median annual budget of $170,000 a year. They offer services to people throughout California but a majority serve the cities of San Francisco and Los Angeles. Our members provide services as diverse as soup kitchens and thrift shops to senior daycare centers and crisis counseling for victims of abuse.

Our largest member, Watts Health Foundation provides health care, substance abuse treatment, services for home bound seniors and is an HMO for 50,000 residents of south central Los Angeles. Another member, Victor Residential Center in Chico, is one of the largest residential and treatment centers for severely emotionally disturbed and abused children and adolescents.

A much smaller member, the League of Volunteers of Newark, marshals 400 volunteers under the supervision of seven paid staff to provide child abuse education, senior companion support, graffiti removal, free summer recreation programs for kids and meals for the homeless.

The Visalia Rescue Mission with only two employees uses the services of 30 volunteers to provide shelter and meals for 59 homeless men, and they do that on a budget of under $50,000 a year. The list of services of our members is as long as the needs in our communities.

If denied tax exempt status, we have been advised that NIAC could avoid most U.S. taxes by forming an insurance company outside the United States which would reinsure all of NIAC's U.S. risks. Further, our members would not be subject to the unrelated business income tax if we followed this course. For many reasons, we would certainly prefer not to have to go through this kind of reorganization.

Clarifying NIAC's tax exempt status under 501(c)(3) is good economic policy and it is good public policy. It is good economic policy because with dramatic funding cuts occurring at nearly every level of government, nonprofits are being forced to do more with less.

NIAC represents possibly one of the best examples of nonprofits' own initiatives to streamline overhead costs and to use more of each dollar for direct services. In addition with tax exempt status, NIAC could leverage private and community foundation grants. We estimate that each dollar granted to NIAC by foundations would be able to save our charitable members an estimated $2 annually.

That is because that dollar donated by foundations can be used as surplus year after year to support the same amount of renewing premium dollar. Over the period of 5 years, each single dollar granted by foundations would have the potential of saving $10 for the charitable community.

That type of cost saving and leveraging of private dollars should be encouraged by government and given room to thrive.

In conclusion, I would like to say that it makes good public policy because more than any other product or service required by the charitable community, liability insurance availability and afford-

ability determines the type and scope of social services that are available to the public.

Nonprofits are powerful vehicles for social change. Many of our members are located in less than desirable neighborhoods, with clients who are far removed in life experiences from commercial insurance underwriters. Commercial insurers are simply not the appropriate people to be deciding which of these social experiments can be undertaken and at what price.

I appreciate the opportunity of speaking to you today and would like to close by two brief comments from two of our members. The words expressed NIAC's mission and accomplishments best. "Many other insurance companies turned down our organization because we deal with individuals with disabilities. NIAC was willing to work with us on a cost that was reasonable and has remained reasonable each year." Special Needs Camp Project.

"Your personal attention to our needs as a small nonprofit organization is extremely rare and wonderful to find. NIAC provides a desperately needed service as evidenced by the dramatic savings your insurance provides us. We are proud to be members of such a worthy organization." Pacific Composers Forum.

Thank you.

[The prepared statements and attachments of the Nonprofits' Insurance Alliance of California, and the County of Alameda, Calif., follow:]

Statement for the Subcommittee on Select Revenue Measures,
Committee on Ways and Means, U.S. House of Representatives

Prepared by: Pamela E. Davis
President/CEO
Nonprofits' Insurance Alliance of California (NIAC)

Introduction

The Nonprofits' Insurance Alliance of California (NIAC) is a liability risk pool exclusively for the benefit of charitable and other nonprofit organizations under California law which are exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code. It provides general liability, miscellaneous professional liability, improper sexual contact liability, directors and officers liability, auto liability and physical damage coverage to its members. It presently has over 800 member-insureds and annual premium of over $4,000,000. All of NIAC's start-up costs and initial capital of $1,600,000 was provided by publicly supported charities and private foundations who are not members of NIAC.

As a part of the Tax Reform Act of 1986 Congress enacted Section 501(m) of the Internal Revenue Code in order to limit the commercial-type insurance activities of certain tax exempt organizations. However, in section 501(m)(3)(A) the Congress expressly recognized that an organization which provides insurance to a class of charitable recipients at substantially below cost should not be considered to be engaged in commercial-type insurance activities.

It is hard to conceive of an organization whose purposes and operations are more consistent with Congressional intent in enacting Section 501(m)(3)(A) than NIAC. Nevertheless, the Internal Revenue Service--by taking an unduly restrictive interpretation of section 501(m)(3)(A)--has denied NIAC tax exempt status under Code Section 501(c)(3).

Organizational structure and governance of Nonprofits' Insurance Alliance of California

Founded in 1988, NIAC was the result of a cooperative effort between community-based nonprofits and a consortium of foundations to help the charitable sector in California establish a source of affordable and stable liability insurance. NIAC is a California nonprofit public benefit corporation operating as a risk pool pursuant to unique authority for such nonprofit risk pools granted by Section 5005.1 of the California Corporations Code. Nonprofit organizations sponsored the enactment of Corporations Code Section 5005.1 for the purposes of reducing and stabilizing liability insurance costs and increasing the availability of insurance coverage for such organizations. This California statue codifies the inherently non-commercial nature of nonprofit risk pools operating thereunder and generally exempts these pools from state insurance regulation.

NIAC's formation costs and all of its initial capital ($1.6 million) were funded by 14 foundations, none of which benefits from NIAC's operation. NIAC is organized as a member-owned nonprofit charitable organizations incorporated in California; its members control the company and elect the Board of Directors annually; and all financial benefits of NIAC ultimately accrue to its tax exempt members. NIAC's assets are irrevocably dedicated to charitable purposes. Moreover, as a nonprofit public benefit corporation, NIAC is subject to special standards for the investment of its funds and extensive supervision by the California Attorney General.

Commercial insurance inadequate

NIAC came into being only because ordinary commercial insurance companies were not adequately meeting charitable organizations' insurance needs. If commercial insurance had been adequate, consistently available, and reasonably priced, NIAC would never have ventured into the insurance arena. At some times, such as the present, insurers readily offer coverage to many, if not all, charitable organizations at reasonable premiums. At other times, when the capacity in the insurance industry is low, insurers desert small charitable organizations in favor of large business clients. Even when coverage is available and affordable, it is often not designed to meet the needs of charitable organizations. Many nonprofits have special needs for coverage for exposures related to extensive volunteer activity, and for unusual exposures such as those relating to improper sexual contact by employees, volunteers or clients.

In a study conducted by Peat Marwick and commissioned by the Independent Sector, 79 percent of the responding charitable organization administrators indicated that their organizations had been hurt because they could not obtain adequate insurance.[1] In another study conducted by the American Society of Association Executives, "The Liability Crisis and the Use of Volunteers by Nonprofit Associations," 14 percent of those charitable organizations polled indicated that they had eliminated programs because of liability insurance problems.[2] The implications of these findings are especially alarming because both surveys canvassed only large organizations. For the small, community-based human service providers that NIAC primarily services, the disruption is more

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[1]Study conducted by Peat Marwick, commissioned by Independent Sector, "D&O Liability: A Crisis in the Making." 1986.

[2]American Society of Association Executives, "The Liability Crisis and the Use of Volunteers by Nonprofit Associations," January 1988.

severe. One study by the United Way of Los Angeles found that a loan program to help nonprofits absorb the annual increase in insurance costs would required funds in excess of $2 million for the Los Angeles agencies alone.[3] In 1986, an Issue Brief published by the United Way of California reported annual insurance premium price increases between 100 and 300 percent for human service agencies and 70 percent for youth serving agencies. A survey by the National Association for the Education of Young Children found that in 1985, 20 percent of child care programs had their insurance canceled or not renewed.[4]

The economics of commercial insurance all but guarantee that periods of low availability and high prices will periodically replace the conditions of adequate availability and more reasonable premiums that currently prevail. For several reasons, this cyclical pattern is much more disruptive for most charitable organizations than it is for for-profit businesses. First, inflexible funding rules limit many charitable organizations' abilities to meet sharp price increases. Unlike the money a business receives from sales, charitable organizations' grant funds typically are limited in how these funds are to be allocated, and the organizations have few discretionary funds with which to cover unanticipated expenses. Second, charitable organizations usually cannot pass along the increased cost of premium increases to their clients. Finally, volunteers, upon whom many organizations depend, are reluctant to expose themselves to the possibility of personal liability. Because volunteers can quit without giving up a paycheck, they are more likely to desert a charitable organizations that loses its insurance than employees are to quit their jobs if their employer is uninsured.

In April 1988, The Ford Foundation funded the Nonprofit Sector Risk Management Project whose task force published recommendations regarding the provision of liability insurance for charitable nonprofits. A few excerpts from the report follow:

> "Over a dozen surveys from the 1984-1988 period, in addition to reams of original source materials, were analyzed. Taken together, the materials amply substantiated the assertions of nonprofit organization administrators and experts that existing legal liability and insurance arrangements are not satisfactory. Although the risk of lawsuits in the face of inadequate and sporadically unaffordable insurance has not brought the nonprofit sector to a standstill, it has adversely affected the delivery of human services."

> "Based on these multiple sources of input, a consensus emerged that nonprofits need to improve their risk management practices, support equitable rules to govern their legal liability, and gain greater control over whatever insurance they must have."

NIAC serves many small community-based nonprofits

NIAC presently has about 800 nonprofit member-insureds. Nearly all of NIAC's members are small community-based nonprofits serving underserved populations in their communities. All of NIAC's members hold current, unrevoked status as tax-exempt nonprofit organizations under Internal Revenue Code 501(c)(3). The median annual budget size of NIAC's members is $170,000. Typical members of this budget size or smaller include: Child Abuse Prevention Training Center of California which brings training on this issue to children of Oakland's public schools; Defensa de Mujeres which provides assistance to abused and battered women, including counseling and shelter assistance, to the women of Watsonville, California; Alliance for Mentally Ill which is a an all volunteer self-help organization of families of persons with serious mental illness such as schizophrenia, manic-depression and severe clinical depression; and Bridge for the Needy which provide residential alcohol recovery services for 20 male residents of South Central Los Angeles. A complete list of NIAC's member-insured is attached to this testimony.

In addition to pooling for insurance, NIAC provides free loss control and risk management services to its members. It provides extensive education and advisory services to its members to help them avert liability claims.

Large charitable organizations generally have the financial resources to provide for contingencies while small organizations do not. As 501(c)(3) nonprofits, NIAC's members would be able to individually set aside tax-free funds for future claims. However, 501(c)(3) organizations which are too small to self-insure, and instead which have cooperated via the mechanism of NIAC to jointly fund claims, must bear the burden of taxation on those pooled funds. We wonder what public purpose is being served by discriminating against the smallest, most financially fragile charities in this manner.

NIAC assists nonprofits serving distressed communities and populations at risk

In addition to serving many of the smallest charities, NIAC provides insurance coverage for nonprofits considered high risk by virtue of the distressed communities in which they are located and/or the various at-risk populations they serve. A few examples are provided below.

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[3]Report on workshops held by the Center for Nonprofit Management, May 1986.

[4]National Association for the Education of Young Children (January 20, 1986).

NIAC's largest member insured is The Watts Health Foundation (WHF). The predecessor organization to the Watts Health Foundation was formed in 1967 to provide health care services to residents of the community located in South Central Los Angeles, California. It provides various health care services including radiology, adult medicine, pediatrics, physical therapy, pharmacy, dental and prenatal care. In 1976, WHF formed a federally qualified health maintenance organization, United Health Plan (UHP), which provides outpatient services to more than 50,000 residents of South Central Los Angeles. WHF's other programs include House of Uhuru inpatient substance abuse programs, and counseling center for substance abuse problems. Its Geriatrics and Homebound Services provides transportation to and from its center where recreation, counseling and nutritional services are provided to seniors. NIAC provides general liability and auto liability coverage for WHF. NIAC does not provide medical malpractice coverages. (A statement from WHF regarding their participation with NIAC has been provided to this Committee.)

Victor Residential Center is also one of NIAC's larger members. Located in Chico, California, Victor is one of the largest residential and treatment centers for severely emotionally disturbed children and adolescents. In 20 locations around the state, Victor provides residential care for 170 children and teens with severe behavioral problems associated with drug and alcohol addictions, physical and sexual abuse and learning disabilities. These children are considered to be the most difficult and highest risk category funded by the state. Victor represents the community alternative to confining these children in a locked setting at state hospitals. Their focus on retaining community and family ties, when possible, increases the possibilities these children have of leading more normal and productive lives.

NIAC provides broad coverages at below commercial market cost

Today, according to our members, they are paying, on average, 30 percent less for coverage with NIAC than they were paying for commercial insurance. Each NIAC member is saving about $2,000, for a total expected savings for NIAC members during 1993 of about $2,000,000. In addition to offering coverages a prices below commercial rates, NIAC offers coverages such improper contact liability that are rarely available from commercial carriers.

NIAC serves a charitable purpose

Few, if any, organizations operating in the insurance or risk management sector can claim, as NIAC can, that they were conceived, organized and funded solely by the nonprofit community. By taking control of their insurance needs, nonprofit organizations in California realized that they could better manage their overall charitable operations. Although NIAC's members benefit from better risk management, reduced insurance costs and increased insurance availability, the true beneficiary of NIAC's charitable operations is the California public.

That NIAC operates exclusively for charitable purposes is further highlighted by its corporate form and the fact that its members must be charities. NIAC is a California nonprofit public benefit corporation which, by law, must exist for public or charitable purposes. Moreover, NIAC is controlled and managed by a volunteer Board of Directors elected annually by its members. NIAC's bylaws provide that the majority of the Board positions be filled by officers, directors or management-level employees of its nonprofit members.

The charitable community has already validated NIAC's value to the public by contributing 100 percent of NIAC's implementation costs and 100 percent of NIAC's initial capital, total funds of $1.6 million. Largely due to NIAC's undetermined tax status, its capital of $1.3 million was provided by foundations as loans on highly concessionary terms, with interest at the rate of 2% and generous subordinated repayment provisions. The six foundations that provided NIAC's capital are: The Ford Foundation, the David and Lucile Packard Foundation, the Wallace Alexander Gerbode Foundation, the Walter S. Johnson Foundation, the San Francisco Foundation and the Marin Community Foundation. The reason these very substantial charitable organizations support NIAC is because NIAC furthers the charitable programs of many of the operating charities which these organization support. Until NIAC receives its tax exempt status under 501(c)(3), private foundations will only make Program Related Investments (loans) to NIAC; support in the form of outright grants presents tax problems for the foundations. Tax exempt status under Section 501(c)(3) for NIAC would open the possibility of converting the loans to grants and would allow NIAC to leverage additional foundation funds to meet its increasing need for capital to serve its growing membership. Because all benefits of NIAC are reserved only for its charitable nonprofit members, investment in NIAC is not attractive or possible for commercial sources of capital.

Attempting to apply a "substantially below cost test" on an annual basis is inappropriate for insurance-like mechanisms

Section 501(m)(3)(A) presently provides tax-exemption for insurance carriers which can demonstrate that they provide coverage "at substantially below cost to a class of charitable recipients." The policy objective is to assure that insurance mechanisms which are granted exemption under Section 501(c)(3) according to the provisions of Section 501(m)(3)(A) fulfill a true charitable purpose by providing continuity in availability and affordability of insurance not otherwise available to their charitable member organizations. However, it is practically impossible to determine whether this goal is being achieved by trying to apply a "substantially below cost" test to annual operating results of an insurance mechanism.

For many companies other than insurance companies, the actual cost of their operations may be easily analyzed. One can then compare the cost of their products or services with the price they charge for such products or services. In contrast, at the time that insurance is written an insurer's actual operational costs are not easily compared with its premium income. Certainly, an insurer incurs "home office" costs, i.e., rent, supplies, utilities, salaries, etc, like any other business. The most significant costs of transacting an insurance business, however, relate to an insurer's payment of claims and claim adjustment expenses, and the maintenance of sufficient capital and surplus to maintain solvency.

Insurance is a contract whereby one agrees to indemnify another against losses arising from a contingent or unknown event. California Insurance Code Section 22. In determining the price of its insurance policies, an insurer must necessarily make certain assumptions. Specifically, an insurer must assume the amount of claims payments and claims adjustment expenses which it will incur on the business written. Further, an insurer must estimate the investment income that it will earn on policyholder premiums, surplus set aside to pay claims, and its owners' equity. An insurer's ultimate costs of operations are impossible to quantify at the time it collects policyholder premium payments. Because of the insurer's assumptions, until all potential insurance claims are settled and paid, there can be no absolute calculation of whether policyholder premium payments are "substantially below cost" within the meaning of Section 501(m)(3)(A) of the Code.

It is for this reason that a clarification to 501(m)(3)(A) is required. Because of the difficulties described in the preceding paragraph, some other criteria must be established to determine whether an insurance mechanism is carrying out a charitable purpose. We have developed proposed statutory language for this purpose and have furnished it to the Congressional staffs.

Other examples provide ample precedent for NIAC to receive tax exemption

There is ample precedent for enterprises serving only the purposes of charitable organizations to be exempt from tax. In the case of the Common Fund, the Congress intervened to prohibit the Internal Revenue Service from withdrawing tax-exempt status from a cooperative investment arrangement, controlled by and serving only charitable institutions. The history of this example is that initially nearly all of The Common Fund's costs were paid for by start-up grants from a private foundation and that eventually The Fund became more reliant upon payments from its member nonprofit institutions. The Internal Revenue Service sought to disqualify The Fund from exemption. At that time Congress made it clear that cooperative arrangements of this type--formed and controlled by the participating charitable organizations themselves--are entitled to tax-exemption. Congress made a distinction between organizations owned and controlled by charitable organizations and private organizations furnishing the same services--even where those services might be made available only to charitable or education organizations. The former may qualify for tax-exemption, the latter do not.

More recently, in 1992, the Tax Court overruled the IRS in the case of The Council for Bibliographic and Information Technologies v. Commission of Internal Revenue. In that case, a group of tax-exempt libraries formed an organization to provide research, computer programs, and computer equipment for library administration to its members, and the Court found that the organization's activities were deserving of tax exemption. The Internal Revenue Service had argued (as they did with NIAC) that the bibliographic service operated as a commercial enterprise; it provided commercial service and, because members' fees covered the expenses of the operation, it was not a charity. The Court disagreed.

In The Council for Bibliographic and Information Technologies v. Commissioner of Internal Revenue, the Tax Court's conclusion has merit. The analysis whether an entity is a charity and entitled to tax exemption must consider all facets of an organization's operating plan--its goals, its history, its funding and its performance. A formulaic test comparing income and expenses of the organization to determine whether a service or product is offered below cost must be flexibly applied and it can never provide the entire answer whether an organization is a charity.

There is a considerable variety of organizations exempt under 501(c)(3) whose purposes are to serve other charities. For example, the California Association of Nonprofits, the Center for Nonprofit Corporations in New Jersey, the Minnesota Council of Nonprofits, the Pennsylvania Association of Nonprofit Organizations, the Washington Council of Agencies, the Nonprofit Coordinating Committee of New York, and the Florida Association of Nonprofit Organizations are just a few of the scores of organizations which are exempt under 501(c)(3) and whose purposes are to provide managerial, financial, organizational, and technical assistance to nonprofits. In addition, The Support Centers across the country which provide management training, information referrals, and technical assistance exclusively to nonprofit organizations are tax-exempt under Section 501(c)(3) Likewise, the Nonprofit Risk Management Center, a 501(c)(3) organization in Washington, D.C., primarily trains other Section 501(c)(3) entities about how to lower their exposure to insurance claims. The Nonprofit Facilities Fund in New York is a 501(c)(3) entity which offers loans at below-market rates for capital improvements to other nonprofit facilities. Non Profit Services, Inc. in California, also tax-exempt under 501(c)(3) sells and distributes previously owned office furniture, acquires and distributes computer equipment and software and conducts management training seminars to members which pay an annual fee for access to these service. With all these financial and technical services provided by tax-exempt nonprofits to other tax-exempt nonprofits for a fee, it is not at all clear why the provision of another financial service, pooling for insurance claims, should

not also be provided under certain specified conditions by tax-exempt entities serving only other charitable tax-exempt organizations.

Tax-exemption for non-commercial insurance contemplated by 501(m)

Although NIAC would be the first non-religious, secular nonprofit to qualify under Section 501(m)(3)(A), it would not be the first nonprofit pooling mechanism or insurance carrier to qualify under the provisions of Section 501(m)(3). Several religious insurance carriers have been granted tax-exempt status under Section 501(m)(3)(C), specifically: The Ordinary Mutual; The National Catholic Risk Retention Group; and the Religious and Charitable Risk Pooling Trust of the Brothers of the Christian Schools and Affiliates. These religious pools are much easier to identify for tax exemption, but clearly NIAC is the prototype of the secular charitable pool that was contemplated by 501(m)(3)(A).

The Offshore Alternative

If it were denied exempt status, NIAC could reorganize its operations so as to substantially reduce or eliminate any U.S. income tax liability. One method by which this could be accomplished would be through the formation of a second insurance company outside the U.S. which would serve as the reinsurer for all of NIAC's U.S. risks. The effect of this arrangement would be that (i) NIAC itself would have minimal U.S. taxable income after deducting its reinsurance premiums, (ii) the offshore company would only be subject to a 1% gross premiums tax on the reinsurance premiums paid to it by NIAC, and (iii) none of the offshore company's residual profits would be subject to tax in the hands of its U.S. tax-exempt shareholders when paid, since any dividends paid by the offshore company would not be taxable as unrelated business taxable income in the hands of the tax-exempt shareholders. Finally, given NIAC's large membership the ownership of the offshore company would be sufficiently dispersed so as to avoid the application of the controlled foreign corporation rules.

Public Policy Implications

With dramatic funding cuts occurring at nearly every level of government, nonprofit social service organizations are being forced to do more with less. NIAC represents an innovative, intelligent and economically sound solution to a very difficult financial problem. Claiming through tax dollars more of the scarce resources available for direct services through these nonprofit organizations would defeat good public policy.

Possibly more than any other product or service required by the charitable nonprofit community, liability insurance coverage availability and affordability has the ability to limit the type and scope of social services that are available to the public. Many small, emerging nonprofits represent the cutting edge of social change in our country. Some of NIAC's smallest members are experimenting with fairly radical ideas for such causes as saving the environment, providing better care for seniors, mentoring troubled inner-city youth, helping to incorporate the disabled into mainstream society, and stopping the cycle of drug addiction. Many of these programs are located in less than desirable neighborhoods, with clients who are far-removed in life experiences from commercial insurance underwriters. Commercial insurers are simply not the appropriate people to be deciding which of these social experiments can be undertaken and at what price. These types of decisions regarding the appropriateness and cost of undertaking the risk of new programs needs to be in the hands of nonprofits themselves, as it is with NIAC. To be able to safely pool the risks of these new and higher risk groups, the nonprofit sector must be able to pool the risks of a broad spectrum of more established nonprofits. To receive available funds from private and community foundations to capitalize a pool of the size required to spread these risk broadly, NIAC must have 501(c)(3) tax-exemption.

Summary

In summary, I submit that approval of tax exemption under Internal Revenue Code 501(c)(3) for the Nonprofits' Insurance Alliance of California (NIAC) is merited by the following combination of facts and circumstances:

- Liability insurance for charitable nonprofits is not consistently available and affordable from commercial insurance carriers;
- Large tax-exempt nonprofits can reserve for contingencies with tax-exempt funds and that same benefit should be accorded to small nonprofits which jointly pool their resources;
- Foundations funded $330,000 in organization and start-up costs for NIAC;
- Foundations provided all $1,300,000 of NIAC's start-up capital;
- None of the contributing foundations are beneficiaries of NIAC:
- NIAC is a nonprofit, public benefit corporation jointly owned by its 501(c)(3) member organizations;
- NIAC is member-controlled by annual election of the Board of Directors;

- NIAC covers liability exclusively for its 501(c)(3) charitable entities;
- NIAC's assets are irrevocably dedicated to charitable purposes;
- NIAC is the prototype of the secular insurance organization contemplated by 501(m)(A)(3);
- NIAC must achieve 501(c)(3) tax-exempt status to access the only sources of capital available to meet the needs of its growing membership;
- It is good public policy to assure that tax-exempt nonprofits can obtain low-cost liability insurance with coverages that are tailored to the special needs of the charitable sector.

WHAT OTHERS SAY ABOUT NIAC

"Not only have we saved money, but the service from NIAC staff is way beyond the call of duty."

- Carol Stone, Volunteer Center of Greater Orange County

"In every case your program (NIAC) has shown a high degree of professionalism and pride and a level of commitment rarely found in our industry. As we face another hard market, I feel very confident that you will continue to provide us with an excellent market for our nonprofit clients."

- Johnny D. Searcy, Searcy Insurance Center, Inc.

"Many other insurance companies turned down our organization because we deal with individuals with disabilities. NIAC was willing to work with us on a cost that was reasonable, and has remained reasonable each year. Special Needs Camp Projects, Inc. is also grateful for being able to obtain a corporate sponsor because of resources made available to us through NIAC."

- Joyce Gilden, Executive Director, Special Needs Camp Projects, Inc.

"Working through our local insurance broker, we were pleased to find an alternative like NIAC where we have a voice in the affairs of the company. In addition to helping us save over $9,000 in premiums, NIAC has assisted us by taking a personal, yet professional risk management approach to our business."

- Jack Bernstein, Executive Director, Cri-Help

"NIAC's approach and attitude makes us feel a part of their team; with all of us working toward providing nonprofit agencies with superior coverages, cost, and professional services. It is a privilege to work with such an outstanding group of professional underwriters, loss control specialists, and administrative staff who really care about nonprofit agencies."

- Tom South, South Insurance Services

"Your personal attention to our needs as a small nonprofit organization is extremely rare and wonderful to find. NIAC provides a desperately needed service as evidenced by the dramatic savings your insurance provides us. We are proud to be members of such a worthy organization."

- Dr. Mark Ruttle, Vice President, Pacific Composers Forum

NONPROFITS' INSURANCE ALLIANCE OF CALIFORNIA MEMBERSHIP 1993

2311 Corporation Itself and DBA Pax House
A Broader Living Expenence dba A B L E.
A Woman's Place of Merced & Manposa
ABC Child Development, Inc.
AD Care Inc . R S V P and Caring Callers
AIDS Community Research Consortium
ARC Vallejo-Benicia
ARC of Amador and Calaveras
Actors' Theatre of Sonoma County, Inc
Adopt International
Adoption for Afncan American Children Com
Afncan Community Refugee Center, Inc
Al Wooten, Jr Heritage Center
Al-Anon Family Groups, Distnct 13
Alcoholism & Drug Abuse Council of Fresno
All Things Right & Relevant
Alliance for the Mentally Ill of San Mateo
Alma School Foundation
Alpha House, Inc.
Alpha Nu Omega Ida L Jackson Foundation
Alpha of San Diego, Inc
Alzheimer's Association - Monterey County
Alzheimer's Association of Orange County
Alzheimer's Services of the East Bay
Alzheimers Association Greater North Valley
Alzheimers Disease/Related Disorders Assn./ Ventura
American Decorative Arts Forum of No. Calif
American Sports Institute
American Theatre Ventures
Amigos de las Americas-Marin Chapter
Anaheim Interfaith Shelter, Inc dba Halcyon
Ananda Marga, Inc
Anderson Marsh Interpretive Assn
Angel Island Association
Angel Island Institute of California
Angel Society of Fallbrook
Anger Management Counseling Services
Ann Martin Children's Center, Inc.
Arcata and Mad River Railroad Historcal Society
Argosy School for Creative Learning
Art Springs Artists' Association
Arte Americas, The Mexican Art Center
Asian Amencan Senior Citizens Service Center
Asian Pacific Health Venture, Inc
Asociacion Campesina Lazaro Cardenas, Inc
Associated Center for Therapy/CSATT
Association of Housing Mngmt. Agents, et al
Attitudinal Healing Center of Sonoma County
Audrey L Smith Developmental Center, Inc.
Baier Foundation, Inc.
Baulines Crafts Guild
Bay Area Black Consortium for Quality Health Care
Bay Area Business Group on Health
Bay Area Fnends of Tibet
Bay Area Women Against Rape
Bay Institute of San Francisco
Beach Cities Coalition for Alcohol & Drug-Free
Beach Flats Housing Improvement Assoc.
Beacon House Assen of San Pedro, Inc.
Beacon House, Inc.
Berkeley Architectural Heritage Association
Bernal Heights Housing Corporation
Better Health Foundation
Better Valley Services, Inc
Big Brothers of San Diego County, Inc.
Big Sister League, Inc.
Big Sur Historical Society, Inc.
Bill Wilson Center
Blind & Vision Impaired Center of Monterey County
Blind Children's Learning Center
Bonita House, Inc. and/or Bonita, Inc
Boys & Girls Club of Harbor City
Boys & Girls Club of Santa Rosa, Inc
Boys & Girls Club of the Hi-Desert
Boys and Girls Club of Southern Marin
Braille Transcnption Project of Santa Clara Co
Breast Cancer Action
Bndge for the Needy, Inc.
Bndge to Asia Foundation
Buddhist Peace Fellowship
Buenaventura Art Association
Butte County Children's World
C A M P
C F S C., Inc
Cachagua Community Center, A Non-Profit Corp
Cal-Pep, Inc
Calif Coalition for Rural Housing Project (CCRH)
Calif. Court Appointed Special Advocate Assn.
Calif. Institute for Clinical Social Work
California AIDS Intervention Training Center
California Association of Nonprofits & N.A.C
California Bluegrass Association
California Channel
California Council for the Promotion of History
California Council for the Social Studies
California Environmental Trust
California Family Action
Calif Foundation on Employment & Disability
California Freedom House Fellowship
California Grey Bears, Inc
California Leadership
California Native Plant Society
California Neuropsychology Services
California Parkinson's Foundation
California Rare Fruit Growers, Inc
California Southern Small Bus Dev Corp
California State Student Association
California Working Group, Inc
Californians for Drug-Free Youth, Inc
Cambridge Community Center
Cantori Domino
Casa Teresa, Inc
Cascade Canyon School
Castro Valley Boys and Girls Clubs
Cat People, Inc., The
Catholic Big Brothers, Inc
Center for Critical Architecture
Center for New Americans
Central Coast Neurobehavior Center
Central Valley AIDS Team
Centro Cultural Latino de San Mateo
Centro La Familia
Challenged Family Resource Center
Chamberlain's Children Center, Inc
Chemical Awareness and Treatment Services
Chico Museum Association
Child Assault Prevention Training Center of CA
Child Quest International, Inc
Child Sexual Abuse Treatment Center of Yolo
Childcare Coordinating Council of San Mateo
Children & Language Pre-school
Children's Placement Service
Chnstian Assisted Recovery Environments, Inc
Chnstian Counseling Service
Chnstmas Dinner Fund, Inc
Circuit Rider Productions, Inc.
Citizens Who Care, Inc.
City Heights Community Development Corp
Ciudad de los Ninos de Salamanca, Inc
Clare Foundation, Inc
Classical Philharmonic of Northern CA
Cleartake Memorial Health Foundation
Coachella Valley Immigration Service
Coastal Preservation Society
Coastside Adult Day Health Center
Coastwalk
Columbian Gardens Improvement Association
Committee on the Shelterless (C.O.T.S.)
Community Action Board of Santa Cruz County
Community Alliance Program for Ex-Offenders
Community Assinc. for the Retarded & Hndppd.
Community Childcare Council of Sonoma County
Community Companions, Inc. & Acme Environment Management
Community Congress of Humboldt County
Community Congress of San Diego
Community Coordinated Child Development Council
Community Environmental Council
Community Living Centers, Inc.
Community Partnership for Youth
Community Treatment Center
Conflict Resolution Program
Continuum HIV Day Services
Contra Costa Alternative School, Inc
Contra Costa County Volunteer Services, Inc
Contra Costa Humane Society
Copper Hill Living & Learning Center
Corner Stone Outreach, Inc.
Corralitos Padres
Corrective Behavior Institute, Inc.
Corriganville Preservation Committee
Corte Madera Larkspur Schools Foundation
Costa Mesa Senior Citizens' Corporation
Council on Aging of Sonoma County
Court Appointed Special Advocates/Santa Cruz
Creative Business Opportunities
Creativity Unlimited
Cri-help, Inc
Cuddly Critters, Inc
Cultural Odyssey
Cupertino Senior Day Services, Inc.
Daly City Emergency Food Pantry
Davis Community Meals
Defensa de Mujeres
Del Norte Senior Center, Inc
Delhi Community Center
Dell Arte, Inc
Delta Housing Development Corp.
Delta Sigma Theta Life Development, Inc
Democratic Management Services, Inc
Dental Health Foundation
Descanso Gardens Guild, Inc
Diabetes Society of Santa Clara Valley
Disabled In Action League
Discipleship Training International
Dixieland Monterey, Inc.
Do It Now Foundation of Southern California
Dolores Street Community Center
Door of Hope
Door to Hope, Inc
Double Check Retreat, Inc
Drug Abuse Alternative Center
E LA Sheriffs' Youth Athletic League
EE's Residential Group Homes, Inc
Earth Communications Office (ECO)
Earth Links, Inc
East Bay Consortium for Elder Abuse Prevention
East Bay Counseling & Referral Agency for the Deaf
East Bay Services to the Developmentally Disabled
East County Community Detox Center
Easter Seal Society of Los Angeles
Eco-Home Network
Ecumenical Council of the Pasadena Area Churches
Education Programs Associates, A Non Profit Corp
Education, Training and Research Associates
El Dorado Arts Council
El Dorado National Forest Interpretive Assoc
El Pajaro Community Development
El Rescate,El Rescate Legal Services & El Refugio, Inc
ElderHelp of San Diego
Elk Grove Historcal Society, Inc
Elmwood Institute
Emanuel Achievement Program
Emeline Child Care Center
Environmental Health Coalition
Episcopal Community Services
Eschalon Foundation
Escondido Historcal Society
Extended Child Care Coalition
FAITH, Family Assistance Involving The Homeless
Fairfax-San Anselmo Children's Center
Faith Hope Counseling Services
Fallbrook Child Development Center, Inc
Fallbrook People to People
Fallbrook Players
Family Builders By Adoption
Family Education Centers
Family Giving Tree
Family Health Education Center
Family Service Agency of Sonoma County
Family Service Association of Butte & Glenn Counties
Family Service Association of No. Santa Cruz Counties
Family Service Association of the Pajaro Valley
Family Services of Tulare County, Inc
Federation of Indian Association
Fifth Business, Inc.
Filipino American Council of San Francisco
Filipino Task Force on AIDS
Filipinos for Affirmative Action, Inc.
Fillmore Historcal Museum
Florence Crittenton Services
Florin Historical Society
Fontana We Care
Food Bank for Monterey County
Foothill Area Community Services, Inc.
Foothill Unity Center
Forest Theatre Guild, Inc.
Foundation Center
Foundation for Educational Software
Foundation for the Performing Arts Center
Frank H & Eva B Buck Foundation
Fred Finch Youth Center
Fresno Adult Literacy Council, Inc.
Fresno Metropolitan Ministry
Fresno Rescue Mission, Inc
Fnends of Jefferson House
Fnends of Robinson Gardens, Inc.
Fnends of San Luis Obispo Botanical Garden
Fnends of Scrap, Inc.
Fnends of Sunset Foundation
Fnends of the Antelope Valley Indian Museum
Fnends of the Arcata Marsh
Fnends of the Mission Cultural Center, Inc.

NONPROFITS' INSURANCE ALLIANCE OF CALIFORNIA MEMBERSHIP 1993

Friends of the San Francisco Health Department
Friends of the Santa Cruz Public Libranes, Inc
Friendship Center for the Blind, Inc
Future Families, Inc
GRASP Foundation
Gay Asian Pacific Alliance, Community HIV Project
Genesis/A Sanctuary for the Arts
German Language School Of Sonoma County
Girls, Inc of San Leandro
Glenn County Seniors Centers
Global Exchange
Global Outlook Educational Institution
Go Productions
Gold Key Club
Golden Umbrella, Inc & Foster Grandparents
Good Shepherd Fund, Inc., The
Grandparents as Parents, Inc
Grant Beckstrand Cancer Foundation
Great Leap, Inc
Greater Pomona Housing Development Corp
Green Pastures, Inc
Greenacre Homes, Inc
Gridley Guardian, Inc
Group Home Society, Inc
Grove Mont Community Theater
H O W Foundation
Haight Ashbury Food Program
Hale Laulima, Inc
Hamilton Family Center, Inc
Hancock Park Elementary School Booster Club
HandsNet, Inc
Harbor Area Gang Alternative Program, Inc
Harbor Gateway Center, Inc
Head Injury Prevention, Inc.
Head Trauma Support Project, Inc
Headlands Center for the Arts
Healthy Babies Project
Help-4-People, Inc
Helping Hands Youth Homes, Inc
Hemophilia Foundation of So Ca
Heritage Village Seniors, Inc
Hi Desert Meals on Wheels, Inc
High Desert Child Abuse Prevention Council
Higher Education Policy Institute
Highlands Senior Service Center, Inc.
Hillsborough Schools Foundation
Hollygrove (dba) Los Angeles Orphans Home
Home Start, Inc
Homeless Care Force, Inc
Homeless Independence Projects
Homeless Prevention Group
Hope for Kids, Inc
Horizon Services, Inc
Hospital Chaplaincy Services
Housing Development And Neighborhood
Human Investment Project of the Peninsula
Human Options
Human Response Network
Humane Society of Calaveras County
Humboldt Connections, Inc
Humboldt Family Service Center
Humboldt Redwoods Interpretive Association
Hunger & Homeless Action Coalition of San Mateo Co
I-Pride, Inc.
Int'l Gay & Lesbian Human Rights Comm
IRAIDA Foundation, Inc
Idyllwild HELP Center
Independent Adoption Center
Independent Housing Services, Inc.
Indian Dispute Resolution Services, Inc.
Infant/Child Enrichment Services, Inc.
Information and Referral Services, Inc.
Inglewood Neighborhood Housing Services
Inland Temporary Homes, Inc
Institute For Food & Development Policy, Inc
Institute for Wildlife Studies
Institute for the Advancement of Human Behavior
Institute for the Study of Somatic Education
Instituto Pro Musica de California
Inter-Faith Shelter Network, Inc.
Interfaith Service Bureau, Inc.
International Church Relief Fund, Inc.
International Gay & Lesbian Archives
International Rivers Network
Inyo Council for the Arts
Irvine Senior Foundation
Jean Weingarten Oral School for the Deaf
Jenifer Altman Foundation
Jesuit Volunteer Corps
Jewish Community Center of Greater San Jose
Jewish Senior Ctr & Genatnc Svs of Orange
Jinan - Sacramento Sister Cities Corp.
Josephine Taylor Foundation
Jovenes de Antano
Jubilee West, Inc.
June L. Mazer Lesbian Collection
Kainos Home and Training Center, Inc
Kans House, Inc
Kay Ceniceros Multi-Purpose Senior Center
Kern County Alcohol Center, Inc
Kern County Hispanic Commission on Drug Abuse
Khepera Recovery Homes
Kids Cancer Connection
Kids' Turn
King's Court Play'rs, Inc.
Kings Community Action Organization, Inc.
Kira Foundation, Inc.
Korean American Community Services, Inc
Korean Community Center of the East Bay
L A Family Housing Corp
L A Tenth Distnct PTA Congress of Parents
LO*OP Center, Inc
La Casa De San Mateo
La Casa de las Madres
La Jolla Community Services, Inc
La Jolla Youth, Inc.
La Monte Academie
La Puente Valley Food Pantry
Lake County Big Brothers & Sisters
Lakeside Historical Society
Leadership Tomorrow
League of Volunteers of Newark, dba LOV Newark
Learning Disability Association of California
Lekotek Family Resource Center
Lemoore Senior Citizens, Inc
Life Lab Science Program
Life Management Institute dba New Horizons School
Lifeline Mission of San Francisco
Light-At-The-End-Of-The-Tunnel Foundation
Lilliput Children's Services
Links to Positive People
Little Tokyo Service Center, Inc.
Live Oak Adult Day Services, Inc.
Live Oak Foundation, Inc
Live Oak Seniors, Inc
Live at Home Foundation
Livermore Heritage Guild
Living in Familiar Environments (L I F E.)
Lompico Community Center
Long Term Care Services of Ventura County
Loretta Livingston and Dancers
Los Angeles Baroque Orchestra
Los Angeles Municipal Art Gallery Associates
Los Angeles Womens Foundation
Los Padres Interpretive Association
M-2/Match Two, Inc.
Madrone Hospice, Inc.
Mann Assn. for Retarded Citizens
Marin Athletic Foundation
Mann Child Abuse Council
Mann Child Care Council
Mann City Children's Program
Marin Community Food Bank
Marin Council of Agencies
Marin Services for Men
Marin Services for Women
Mariposa Golden Agers, Inc.
Mariposa School
Math/Science Technology Foundation
Matrix
McDowell Youth Homes, Inc.
Meadowlark Service Leegue
Meals on Wheels of San Francisco, Inc
Meals on Wheels of the Monterey Peninsula, Inc
Meeting Place, The
Mendocino Area Parks Association
Mendocino Coast Botanical Gardens Presrvtn
Mendocino County Public Broadcasting KZYX Radio
Mental Research Institute
Mid City Chnstian Services, Inc.
Mid-Weeklies, Inc.
Mini Twelve Step House, Inc
Miracle House, Inc.
Mitchell-Redner Centers, Inc.
Molecular Research Institute, Inc.
Monterey Bay Girl Scout Council, Inc
Monterey County Homeless Coalition
Monterey County Theatre Alliance
Monterey County Vietnem Veterans Memorial Committee
Morning Out Club
Morongo Basin Adult Health Services Corp.
Morongo Basin Mental Health Services
Mother Lode Ombudsman, Inc
Mountain Crisis Services
Mountain Empire Historical Society
Mt Diablo Interpretive Association
Mt San Jacinto Natural History Association
Mt Tamalpais Interpretive Association
NCI Affiliates, Inc
Na Ohana O Ke Awawa
Naamans Fellowship
Napa Emergency Women's Services
Napa Valley Natural History Association
National Federation of the Blind of Calif. Inc.
National Task Force on AIDS Prevention
Natural History Assn of San Luis Obispo Coast
Neighborhood House of North Richmond
Nepenthean Homes Foster Family Agency
New Directions Adolescent Services, Inc
New Directions for People with Disabilities, Inc.
New Fillmore Community Theater, Inc.
New Learning School
New Performance Consort, Inc
New Start
New Testament Community Outreach
No Ca Chapter of the National Hemophilia Foundation
North Coast Big Brothers/Big Sisters Inc
North Coast Rape Crisis Team
North Coast Redwood Interpretive Association
Northern California Ecumenical Council, Inc.
Northern California Service League
Northside Comm Ctr Filipino/Am Sr. Oppor Development
Northwestern Pacific Railroad Historial Society
Novato Ecumenical Housing, Inc
Novato Human Needs
Novato Youth Center
OMI Neighbors in Action
Oak Center Cultural Center, Inc
Oakland Community Fund
Ocean Park Community Center
Ombudsman Services of Contra Costa, Inc.
Ombudsman/Advocacy Services of Inyo/Mono
Omni Programs, Inc./Peers Against Substance Abuse
On Our Own, Inc
One Shoe Crew
Ontario-Upland Meals on Wheels
Open Sea Foundation
Orange County Community Consortium, Inc.
Orange County Community Development Counca
Orange County Consolidated Transportation
Orange County Intergroup of Overeaters Anonymous
Orange County Refugee (C.R O P.)
Orange Housing Development Corp
Orchidmania, Inc
Organized People of Elmhurst Nghbrhd (OPEN)
PACT (People Acting in Community Together)
PARCA
Pacific Autism Center for Education (P A C E.)
Pacific Chorai Company
Pacific Composers Forum
Pacific Intercultural Exchange
Pacific Theatre Ensemble
Pajaro Valley Affordable Housing Corp
Pajaro Valley Historical Association
Pajaro Valley Prevention & Student Assistance
Pajaro Valley Shelter Services
Paradise Strive Center, Inc
Parent Services Project, Inc.
Parent Teacher Counselor Association
Parenting Network, Inc.
Parents Center, Inc
Parents Helping Parents, Inc. (PHP)
Parents United
Parents of Success
Pasadena Childrens Training Society
Pathways
Patient Assistance Foundation
Peg Taylor Center for Adult Day Health Center
Peninsula Alano Club
Peninsula Area Information & Referral Service
Peninsula Community Foundation
Peninsula Humane Society, Inc.
Peninsula League
Peninsula Network of Mental Health Clients
Peninsula Outreach Welcome House
People Assisting the Homeless
People Helping People
Performing Stars of Mann
Pioneer Home Outreach, Inc.
Plaza De La Raza
Plumas Crisis Intervention Resource Center
Poplar Center, Inc.
Poppy Reserve Interpretive Association

NONPROFITS' INSURANCE ALLIANCE OF CALIFORNIA MEMBERSHIP 1993

Porterville Gleaning Seniors, Inc
Porterville Halfway House
Prader-Willi California Foundation
Preservation Action Council of San Jose
Prime of Life, Inc.
Private Industry Council
Process Therapy Institute, Inc.
Programs Plus, Inc
Project 90, Inc & Project 90 Foundation
Project Enable
Project Hope of Santa Cruz County
Project Interface Institute
Project Sanctuary, Inc.
Project Scout, Inc
Project Seed, Inc
Project Understanding
Protect the Children Resource Center
Public Art Works
Pueblo Y Salud, Inc.
R House, Inc.
R-SB Harbinger Corporation
Radiology Research and Education Foundation
Refugee Transitions
Resolve of Northern California, Inc.
River City Recovery Center, Inc.
Riverside Medical Clinic Foundation
Riverside Mental Health Association
Rosamond Senior Citizens, Inc
Rosemary Cottage, Inc
Roseville Community Health Foundation
Ross Valley Community for Schools
Rubicon Children's Center, Inc
Rural Human Services, Inc.
Rural Opportunities Resource Center, Inc.
Russian River Jazz Festival
S.C. County Animal Welfare Assn., Inc.
S E E Center
SHELTER, Inc.
SITIKE
SMILE, Inc
SMOOTH, Inc
Sacramento Center for Assistive Technology
Sacramento History Museum Association
Sacramento Mutual Housing Association
Sacramento Occupational Advancement Resources, Inc
Sacramento Women's Center
Salud Para Los Dientes
Samadana, Inc.
Samaritan House
San Benito Health Foundation
San Benito Hospice, Inc.
San Clemente Seniors, Inc *
San Diego Christian Servicemen's Center
San Diego County Parks Society, Inc.
San Diego Youth Symphony, Inc
San Francisco African American Historical & Cultural Society
San Francisco Arts & Education Foundation
San Francisco Black Coalition on AIDS
San Francisco Children's Art Center
San Francisco Educational Services, Inc.
San Francisco Family Foundation
San Francisco Friends of the Urban Forest
San Francisco Homeless Task Force
San Francisco Housing Development Corporation
San Francisco League of Urban Gardeners
San Francisco Montessori School
San Francisco Network of Mental Health Clients
San Francisco Psychotherapy Research Group
San Francisco Women Lawyers Foundation
San Gabriel Valley Alliance for the Mentally Ill
San Gorgonio Child Care Consortium
San Gorgonio Volunteer Association, Inc.
San Jacinto Valley School of the Arts
San Luis Obispo Children's Museum
San Luis Obispo County AIDS Support Network
San Luis Obispo Literacy Council
San Mateo Coast Natural History Association
San Pasqual Battlefield Volunteer Association
Santa Barbara Rape Crisis Center/De Mano A Mano
Santa Clara County Committee for Employment of Disabled
Santa Clara Historical & Genealogical Society
Santa Clara Valley Multi Service Center
Santa Cruz Bluegrass Society
Santa Cruz Citizen's Committee for Homeless
Santa Cruz Community Counseling Center, Inc.
Santa Cruz County Symphony Association
Santa Cruz County Youth Symphony
Santa Cruz Lesbian & Gay Community Center
Santa Cruz Mountains Natural History Assoc.
Santa Maria Association for the Retarded
Santa Maria House, Inc.
Santa Monica Symphony Association, Inc
Santa Paula Theater Center
Santa Ynez Valley Senior Advisory Council
Saratoga Area Senior Coordinating Council
Saratoga Historical Foundation
Save the Whales, Inc.
Schola Cantorum
School of Humanities & the Arts Alumni Association
Second Chance Youth Program
Seeking It Through Exhibitions dba SITE
Seneca Residential and Day Treatment Center
Senior & Disabled Citizens Coalition
Senior Daycare Center/David Kahn Center, Inc
Senior Legal Center of Northern California, Inc
Sentinel Fair Housing
Sequoia Dawn Seniors Club
Services Center for Independent Living (SCIL)
Sexual Assault and Domestic Violence Center
Shakespeare San Francisco
Shalan Foundation
Sierra Adoption Services
Sierra Recovery Center, Inc.
Sierra Vista Center
Silent Way
Silicon Valley Toxics Coalition, Inc
Siskiyou Adult Learning Center
Siskiyou Child Care Council, Inc
Siskiyou Domestic Violence Program
Siskiyou Performing Arts Center
Siskiyou Youth Shelter
Sledgehammer Theatre, Inc
So Alameda County Domestic Violence Law Project
Society for Calligraphy
Society for the Preservation of Carter Railroad
Sojourner Truth Foster Family Srvc Agency, Inc
Solano Adult Day Health Care Center
Solano Family and Childrens Services
Sonoma Child Guidance Institute
Sonoma City Opera
Sonoma Co Academic Fndtn/Excellence in Medicine
Sonoma County A I D.E.
Sonoma County Alzheimers Task Force
Sonoma County Christian Network, Inc.
Sonoma County Community Foundation
Sonoma County Council for Community Services
Sonoma County Head Trauma Network, Inc.
Sonoma Cnty People for Economic Opportunity
Sonoma County Rental Information & Mediation
Sonoma County Respite Services, Inc
Sonoma State Historic Park Association, Inc
Sonoma Valley Chorale, Inc
Sonshine Youth Services
Soroptimist House of Hope, Inc
South Central Food Distributors
South Coast Children's Services, Inc.
South County Performing Arts Bldg Foundation
South Valley Symphony Association, Inc.
Southern Ca. Veterans Service Council
Southern Calif. Assoc. for Non-Profit Housing
Southern California Ecumenical Council
Southern California Rehabilitation Services, Inc.
Southern Regional Resource Center, Inc.
Southwest Community Center
Southwest Wetlands Interpretive Association
Spanish Speaking Unity Council of Alameda Co.
Spare A Dime
Speech & Language Development Center
Spinal Cord Injury Research Foundation
Spiritual Emergence Network
Squaw Valley Creative Arts Society
Stanislaus County Child & Infant Care
Stepping Out Housing, Inc
Stiles Hall
Stockton Youth Foundation
Substance Abuse Foundation
Suicide Prevention Center of Monterey County
Sumeg Patricks Point Lagoons Interpretive
Summer House Inc & Davis Summer House, Inc.
Summit League, Inc., The
T.E.A.C.H., Inc.
Tahoe Turning Point, Inc.
Tax-Aid
The Names Project
Timpany Center
Toyo Kami, Inc dba Ohana Cultural Center
Travelers Aid Society of Los Angeles
Traveling School, Inc.
Tree Musketeers
Tri-County Easter Seal Society
Triad Community Services
Trinity Education Center, Inc
True to Life Counseling
Tulare County Children's Receiving Home, Inc.
Tulare County Lao Family Community, Inc.
Tuolumne Calaveras Association
Turning Point Foundation, Inc
Turning Point of Central California
Turnoff, Inc.
United Cancer Research Society
United Citizens Against Drugs
United Lumbee Nation of N.C. and America
United Way of Humboldt
United Way of Indian Wells Valley
United Way of Northern California
United Way of Orange County
University Religious Center & Friendly Visitor Services
Urban Resource Systems
Valley Advocacy & Communications Center
Valley Churches United
Valley Oak Children's Services, Inc
Valley Restart Shelter, Inc
Valley Teen Ranch, Inc
Valley Women's Center, Inc & Family Recovery
Valley of the Moon Natural History Association
Ventura Co Coalition Against Household Violence
Ventura Institute of Technology
Verdugo Woodlands Dads Club, Inc
Veteran's Memorial Center, Inc
Victor Residential Center, Inc
Vida Nueva
Vietnam Veterans of California, Inc.
Vietnamese American Cultural & Social Council
Villa Center, Inc
Vintage House Senior Multipurpose Center
Visalia Rescue Mission, Inc.
Voices for Children, Inc
Voices of California, Inc.
Volunteer Center of El Dorado County
Volunteer Center of Greater Orange County
Volunteer Center of Monterey County
Volunteer Center of San Francisco
Volunteers of America of Los Angeles
WATCH (Women and their Children's Housing)
Wajumbe Cultural Institution, Inc
Walden Center Elementary School
Washington Union Educational Foundation
Watts Health Foundation, Inc./United Health Plan
Welfare Action
Welfare Parents Support Group, Inc
West Antelope Valley Educational Foundation
West Bay Local Development Corporation
West Santa Rosa Local Action Council
West Valley Fish, Inc
Western Addn Senior Citizens Svs Center
Western Institute Foundation For Mental Health
Western Sonoma Cnty Swimmers, Inc
Western Youth Services, Inc.
White Hawk Indian Council for Children
White Lotus Foundation
Whiteside Manor, Inc
William G. Irwin Charity Foundation
William James Association
Willits Community Theatre
Wilmington Boys' & Girls' Club
Winifred Baker Chorale
Winters Christian Academy
Women's Alliance
Women's Center-High Desert, Inc.
Women's Crisis Support & Shelter Services
Women's Economic Agenda Project
Women's Initiative for Self Employment (WISE)
Y.W.C.A.
YWCA, Inc. dba: Born Free
Yolo Alcoholic Recovery Center, Inc.
Yolo Family Service Agency
Yolo Wayfarer Center
Young Audiences of the Bay Area, Inc
Youth & Family Services, Inc.
Youth Development Center
Youth Focus, Inc.
Youth Intervention Program
Youth Music Monterey
Youth Revival, Inc.
Youth for Change
Youth-on-the-Move, Inc
Yuba Feather Communities Services, Inc
Yuba-Sutter Gleaners Food Bank, Inc
Yuba-Sutter Legal Center Rep. Payee Project

Statement before the Subcommittee on Select Revenue Measures
Committee on Ways and Means,
U.S. House of Representatives
June 29, 1993

Prepared by: Don Perata
Supervisor, Third District
Board of Supervisors
County of Alameda

This statement is in support of an amendment to the Internal Revenue Code to clarify the status of the Nonprofits' Insurance Alliance of California as an organization exempt from tax under Section 501(c)(3).

The County of Alameda in California relies on tax-exempt nonprofit organizations to provide many of the social services required by the people of Alameda. In fiscal year 1992-93 the County directed approximately $79.4 million of its $1.1 billion general fund budget to community-based organizations. These service organizations provide services ranging from providing hot meals to homebound seniors to crisis support services for families and youth, to providing basic nutritional and health education to young mothers at risk. A list of the Alameda County nonprofits served by the Nonprofits' Insurance Alliance of California (NIAC) is included with this statement.

During the mid-1980s, Alameda County discovered the huge detrimental impact the insurance industry could have on the provision of social services to the people of this county. During that period, the nonprofits on which we rely to provide services to those in need in our communities, could not find affordable liability insurance. Many could not find liability insurance coverage at any price. Some paid high prices for coverages. After investigation, we determined that the unwillingness of the insurance industry to provide affordable coverage did not stem from any available statistics showing that nonprofits were a high risk group.

In 1987, the County of Alameda Board of Supervisors charged the County Risk Manager to find a long-term solution to this problem of sporadic availability of liability insurance for our county nonprofits. In the process of investigating how we might organize our own risk pooling mechanism for Alameda County, the Risk Manager met those who were organizing NIAC. We were impressed with the organizational structure proposed for NIAC. In particular, it was important for us that any mechanism we endorsed be owned and controlled by the nonprofit members themselves. To that end, our Risk Manager served as a founding Board Member of NIAC and assisted in the transition to a board controlled exclusively by the member organizations. We are extremely supportive of NIAC's work in Alameda County and urge Congress to recognize its extensive contributions to the charitable community in California by extending 501(c)(3) tax-exempt status to NIAC.

Although the liability insurance market has experienced a period of relative stability over the past several years, we anticipate that periods of unavailability and unaffordability will continue to plague charitable nonprofits. These nonprofits simply do not have the flexibility of funding and operations to cope with unpredictable conditions. NIAC represents that stable solution for California nonprofits.

With dramatic funding cuts occurring at nearly every level of government, social service nonprofits are being forced to do more with less. NIAC represents an innovative, intelligent and economically sound solution to a very difficult financial problem. California nonprofits deserve to be commended for this work and given every possible consideration including providing NIAC with 501(c)(3) status.

MEMBERSHIP - ALAMEDA COUNTY
June 15, 1993

Alpha Nu Omega Ida L. Jackson Foundation
Alzheimer's Services of the East Bay
Ann Martin Children's Center, Inc.
Bay Area Black Consortium for Quality Health Care
Bay Area Women Against Rape
Berkeley Architectural Heritage Association
Bonita House, Inc. and/or Bonita, Inc.
Bridge to Asia Foundation
Buddhist Peace Fellowship
C.A.M.P.
Cal-Pep, Inc.
California Institute for Clinical Social Work
California Family Action
California Working Group, Inc.
Castro Valley Boys and Girls Clubs
Child Assault Prevention Training Center of California
Classical Philharmonic of Northern California
Columbian Gardens Improvement Association
Community Association for the Retarded and Handicapped, Inc.
Creative Business Opportunities
East Bay Counseling & Referral Agency for the Deaf
Elmwood Institute
Family Builders By Adoption
Federation of Indian Association
Filipinos for Affirmative Action, Inc.
Fred Finch Youth Center
Girls, Inc. of San Leandro
Gold Key Club
Hale Laulima, Inc.
Healthy Babies Project
Horizon Services, Inc.
I-Pride, Inc.
Indian Dispute Resolution Services, Inc.
International Rivers Network
Jesuit Volunteer Corps
Jubilee West, Inc.
Korean Community Center of the East Bay
League of Volunteers of Newark, dba: LOV Newark
Learning Disability Association of California
Light-At-The-End-Of-The-Tunnel Foundation
Livermore Heritage Guild
New Performance Consort, Inc.
Oak Center Cultural Center, Inc.
Oakland Community Fund
Organized People of Elmhurst Neighborhood (OPEN)
Pacific Choral Company
Project Interface Institute
Project Seed, Inc.
Rubicon Children's Center, Inc.
Seneca Residential and Day Treatment Center
Sentinel Fair Housing
Southern Alameda County Domestic Violence Law Project
Spanish Speaking Unity Council of Alameda county
Stiles Hall
Toyo Kami, Inc. dba: Ohana Cultural Center
Walden Center Elementary School
Women's Alliance
Women's Economic Agenda Project

BOARD OF SUPERVISORS

June 21, 1993

DON PERATA
SUPERVISORIAL DISTRICT

Honorable Board of Supervisors
Administration Building
Oakland, California 94612

Dear Board Members:

Subject: Statement before the Subcommittee on Select Revenue Measures
Committee on Ways and Means,
U.S. House of Representatives
June 29, 1993

Recommendation

It is recommended that the Board of Supervisors:

1) Approve the attached statement in support of adoption of an amendment to the Internal Revenue Code to clarify the status of the Nonprofits' Insurance Alliance of California as an organization exempt from tax under Section 501(c)(3).

2) Authorize submission of the attached statement before the subcommittee on Select Revenue Measures Committee on Ways and Means, U.S. House of Representatives for a hearing schedule for June 29, 1993.

3) Authorize Pamela E. Davis, President/CEO of Nonprofits' Insurance Alliance of California (NIAC) to serve as the designated representative for Alameda County.

Background

In 1987 non-profits approached my office requesting assistance in meeting existing County insurance requirements. Generally, non-profits were finding it difficult to bear the costs associated with the various required liability and auto insurances. Without intervention, non-profits would have been left to the mercy of insurance companies who appeared to be fairly capricious in their ongoing treatment of community-based organizations (CBO).

Several meetings were held at that time with Pamela Davis who assumed leadership for this effort. At the direction of the Board, the County's Risk Manager worked closely with Pamela Davis to form what is now NIAC. Together we've worked to ensure that Alameda County goes on record in support of eliminating inequitable insurance rates for CBOs which are essential to the provision of effective service delivery in Alameda

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County. NIAC has managed to assist non-profits in attaining lower insurance rates as well as to stabilize their coverage over time. Much of this initial dialogue served as a precurser to subsequent Proposition 103 activism.

Discussion

On June 24, 1993 the Subcommittee on Select Revenue Measures, Committee on Ways and Means, U.S. House of Representatives will hear testimony and receive written statements relative to a proposed amendment to the Internal Revenue Code which would aid NIAC in accessing the only identified sources of capital available, i.e., foundations.

Currently, NIAC is receiving low-interest foundation loans, however, 501 (c)(1) status would make NIAC eligible for foundation grants. Member community-based organizations are on an average experiencing an estimated 30 percent savings over commercial insurance rates.

NIAC President/CEO, Pamela Davis reports that a recent actuarial report confirms that NIAC reserves are adequate and at appropriate levels. NIAC, however, has $1.3 million in loans which could be supplanted by grant money and lessen the agency's indebtedness.

Summary

Your Board is requested to adopt the attached written statement in support of an amendment to the Internal Revenue Code clarifying NIAC's status as an organization exempt under Section 501(c)(3). It is anticipated that the lowered coverage non-profits are currently receiving would be sustained and possibly reduced further.

Very truly yours,

DON PERATA
SUPERVISOR, THIRD DISTRICT

DP:CDJ:ngr
Attachment
cc: Steve Szalay, County Administrator
Nancy Bellard, Risk Manager
Agency/Department Heads

GG\NONPROFI CDJ

On motion of Supervisor Perata, seconded by Supervisor King, the FOREGOING MINUTE ORDER was passed and adopted by the following vote of the Board of Supervisors, County of Alameda, State of California on June 22, 1993, to wit:

APPROVED AS RECOMMENDED:

AYES: Supervisors Carson, King, Perata, Steele and President Campbell - 5

NOES: None

EXCUSED: None

FILE #6761
AGENDA #11A

* * * * * * * *

I CERTIFY THAT THE FOREGOING IS A CORRECT COPY OF A MINUTE ORDER ADOPTED BY THE BOARD OF SUPERVISORS, ALAMEDA COUNTY, CALIFORNIA JUN 22 1993

ATTEST: JUN 22 1993

WILLIAM MEHRWEIN, CLERK OF THE BOARD OF SUPERVISORS

BY: Shoreleen

STATEMENT OF DONALD A. UDSTUEN, CHIEF OPERATING OFFICER, ILLINOIS STATE MEDICAL INSURANCE SERVICES, INC., CHICAGO, ILL., ON BEHALF OF PHYSICIAN INSURERS ASSOCIATION OF AMERICA

Mr. KOPETSKI. Mr. Udstuen.

Mr. UDSTUEN. I am here as the chief operating officer of the Illinois State Medical Insurance Services, Inc.

We insure 10,000 physicians in Illinois, and we were formed when private carriers pulled out of the medical malpractice marketplace. I also represent the Physician Insurers Association of America, which is comprised of 45 physician-owned companies from around the country.

The reason I am before you is because our problem comes from the 1986 Tax Act. I don't think this committee intended to create this problem, but we come here to seek some relief. Representing physician-owned companies, as this problem materialized we sought help by contacting Chairman Rostenkowski and Congressman Reynolds in Illinois. There are other physician-owned companies around the country, including one in your own State, Mr. Chairman, that have the same problem.

The 1986 Tax Act required the discounting of reserves for the purposes of paying taxes. In those days most of us were selling the occurrence policies which had a very different payout pattern. We were forced to convert to claims-made through reinsurance requirements. Most of us are reinsured through the London market. Claims-made has a much faster payout pattern.

In the malpractice insurance area, you are required to go back 10 years in experience to calculate your taxes. As we came across this problem, and it was presented that we are now selling claims-made versus occurrence. Treasury responded by creating rule 91–21, which much more accurately reflected the claims-made payout pattern and much more fairly assessed our taxes.

The only problem with that ruling is it only lasted 5 years, and it ran out in 1991. In 1992 each of these companies will have to pay significantly more taxes because if we go back on our claims experience for 10 years, we go back into our occurrence years, which has a very different payout pattern when we calculate our current experience.

Our purpose here is to ask this committee to consider putting back in rule 91–21 for at least a couple of more years so that we can have a complete claims-made payout pattern which much more reflects economic earnings.

Just to give you an example, one of the rival companies in Illinois, and I generally don't speak about rival companies, but I feel that this is an important issue, this year in 1992 they lost $200,000 in operations, but because of this tax change they are going to have to pay $600,000 in taxes.

Mr. Chairman, this is not, I don't think, the way the committee meant this system to work. The extension of rule 91–21 would help very much in getting a proper taxing base for our members. I think what we all see is that you should treat companies equally. There are a few companies that have only sold claims-made policies, so their history is strictly in claims-made. They pay different taxes

than the companies that previously sold the occurrence, yet we are in exactly the same business, and we should all be taxed equally.

We are willing to pay at 100 percent of our economic earnings, all the companies are. We have a problem when we are asked to pay at 120 and 130 percent of our economic earnings. At the end of the day, we will pay the same amount of taxes.

The problem is in the way the tax is calculated we will be paying the taxes in much faster and getting it back much slower. Just to give you an example, this is a long tailed business, in Cook County, which is Chicago, it is 6 years from the date of occurrence until the day you ever get to the courthouse. That is a long time to hold reserves, and if you have to pay taxes without rule 91–21 on those reserves, this will keep companies from acquiring the types of reserves they need.

Then you have to charge more because the regulators want proper reserves. You have to charge your members more in order to fill those reserves, even though you will get these refunds in 6 or 7 years.

Mr. Chairman, we look for this kind of relief because this was created by the 1986 Tax Act. We don't think it was an intended portion of it. Treasury gave us relief for 5 years because they saw the same problem and they agreed that the payout pattern was different between claims-made and occurrence, the problem is they didn't see the problem long enough because most of us converted in 1984, 1985, 1986 to claims-made.

We needed rule 91–21 to run to that period. We are not asking this change forever, but until we have 10 years of claims-made experience, then, Mr. Chairman, we can use our own experience, pay our taxes appropriately, which we are more than willing to do. This is an important issue for us.

We would like each company taxed similarly because we are all in the same business. Our job is providing malpractice insurance to physicians. Many of the hospitals you heard from today about the inner city health care problem, those are physicians that I or my fellow companies insure and provide that liability coverage. We don't want to drive the cost of this up any higher than is absolutely necessary to provide that good protection for physicians.

I am not in all the other lines of business. I don't insure cars, health, and all these other things. Our job is to provide medical malpractice insurance for physicians so they can practice the kind of medicine whether it is in the rural area or the inner-city area.

It started with the 1986 Tax Act. We come back to this committee to ask for your assistance for fair taxation on this issue.

Thank you, Mr. Chairman.

Mr. KOPETSKI. Thank you, Mr. Udstuen.

[The prepared statement follows:]

TESTIMONY

OF

DONALD A. UDSTUEN

CHIEF OPERATING OFFICER
ILLINOIS STATE MEDICAL INSURANCE SERVICES, INC.
CHICAGO, ILLINOIS

Mr. Chairman, Members of the Committee, I am Donald Udstuen and I am the Chief Operating Officer of the Illinois State Medical Insurance Services, Inc. of Chicago, Illinois. My company is one of the largest doctor-owned medical malpractice insurance companies in America, insuring over 10,000 doctors and osteopaths in Illinois.

I am grateful for the opportunity to testify in support of the proposal by Representative Mel Reynolds which would clarify the Congressional intent with respect to the proper discounting of loss reserves rules for medical malpractice insurance companies.

In the Tax Reform Act of 1986, the Congress included a provision which required property and casualty insurance companies to discount their loss reserves. The purpose of this requirement was to make sure that the reserves were not overstated and that, accordingly, the companies were paying tax on all of their economic income. The Act directed the Treasury to set forth the methodology for this discounting which reflects, to the extent possible, the actual loss payment pattern with respect to each line of insurance business. This is necessary because the loss payment patterns differ based on the kind of insurance and the types of policies written.

Medical malpractice insurance has what is called a "long tail" payment pattern that can be as long as fifteen (15) years between the collection of the premiums and the payment of the claims. Historically, medical malpractice insurers used a policy form called occurrence which had a payout pattern of four to six years. By the mid-eighties, however, most PIAA companies were writing claims-made policies which have a two to three year payout pattern. However, the IRS requires each company to use ten years of actual expiration in calculating these payout patterns. As a result, when the 1986 Act became law, many of our companies were in a bind. Since we had switched from occurrence to claims-made but had less then ten years of claims-made experience our taxes were increased artificially because the factors used to calculate the loss reserves were based more on "occurrence" experience than "claims-made" experience.

In 1991, the IRS recognized this problem and issued Rev. Proc. 91-21 which allowed PIAA companies to use a composite schedule of factors which reflected more claims-made experience. As a result, a more accurate reflection of our appropriate tax liability was possible. Rev. Proc. 91-21, while helpful, lasted only five years (1987-1991), even though most of the PIAA companies still do not have ten years of actual experience under the claims-made form.

In 1992, the IRS reversed its policy in Rev. Proc. 92-76 which confused the situation greatly by reducing the number of years necessary to utilize a company's own experience from ten to five years but adding a new condition which required that the companies have 77% of their estimated ultimate losses paid in any two of those five years. Many PIAA companies cannot meet this latter test and, thus, continue to be overtaxed. It is important to note that this Rev. Proc. was issued in September of 1992 but is applicable retroactively to January of 1992 and prospectively until 1997.

Simply, this is the wrong result from a practical as well as a policy basis. These companies should not be overpaying taxes simply because the IRS and the Treasury have not taken the time to do what everyone agrees should be done, namely, to issue separate "occurrence" and "claims-made" factors. Nor should it be necessary to have to wait another five years for the next determination period. As a practical matter, the Treasury should do this as soon as possible and our companies should not be required to overpay their taxes in the interim.

From a tax policy standpoint this has a number of problems.

1. Similarly situated companies in the same industry are being taxed very differently simply because of the timing of a business decision made prior to a change in the law. This means that certain companies have a significant competitive edge over others as a result of their tax situation.

2. This tax situation effectively precludes any new company from entering this business. Since any new company would be a claims-made company but would be taxed as an occurrence company, as an economic matter, it could not get into this business. The tax laws should not prevent new companies from entering the market.

Representative Reynolds has submitted a proposal which would provide transitional relief to these companies only until the Treasury issues separate "occurrence" and "claims-made" factors. It simply allows us to pay tax on 100% of our economic income rather than on 120% to 130% of our economic income. We believe this is fair and will provide a real incentive to the Treasury to publish separate factors to achieve the result which is fair and consistent with the action taken by the Congress in the Tax Reform Act of 1986.

We urge your consideration of this proposal.

Mr. KOPETSKI. Before I get into the question period, I want to ask unanimous consent to have Mr. Matsui's statement entered into the record on the 501(m) issue. Without objection, so ordered. As well as the testimony or the written statement from Dr. Rosenfield who was on our first panel, I believe, to have his entire statement made part of the record. Without objection, so ordered.

[The statement of Mr. Matsui follows. The written statement of Dr. Rosenfield appears on page 59:]

ROBERT T. MATSUI
FIFTH DISTRICT, CALIFORNIA

COMMITTEE ON
WAYS AND MEANS

SUBCOMMITTEE ON HUMAN RESOURCES
SUBCOMMITTEE ON TRADE

WHIP AT LARGE

Congress of the United States
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DISTRICT OFFICE
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June 29, 1993

Dear Chairman Rangel:

Today, your Subcommittee on Revenue Measures will conduct a hearing with regard to the tax treatment of health maintenance organizations. I have a strong interest in this subject, and respectfully request that you and your Subcommittee carefully consider recommending clarifying legislation relating to the application of Section 501(m) of the Internal Revenue Code.

Despite the fact that Congress, through the Tax Reform Act of 1986 and the Technical Corrections and Miscellaneous Revenue Bill of 1988, clearly intended to exempt certain non-commercial HMO-like organizations from taxation, the Internal Revenue Service continues to refuse to grant exemptions to Vision Service Plan, a California non-profit company and it's affiliates.

Vision Service Plan operates in the same manner as an HMO. It provides services for payments on a periodic basis. VSP contracts with individual eyecare professionals; makes services available with reasonable promptness assuring continuity; operates in a fiscally sound manner under sound administrative and managerial arrangements; assumes financial risk for the services provided; and assures that members will not be liable for services rendered under the Plan. Members cannot be expelled or refused re-enrollment because of health status of the services needed. Vision Service Plan provides representation of members on an advisory board; provides procedures for hearings to resolve disputes between the Plan and the members; contains a quality assurance program; provides utilization review and cost review; and provides for the confidentiality of the provider/patient relationship.

In the 1986 Tax Reform Act, Congress adopted language which was designed to address our concern that tax exempt organizations that engage in insurance activities may well be engaged in an activity which is inherently commercial, rather than charitable in nature. The provision which we enacted in 1986, and which we clarified in the Technical Corrections and Miscellaneous Revenue Act of 1988, were not, however, intended to alter the tax exempt status of qualified health maintenance organizations. Indeed, the provisions which we enacted in 1988 further clarified that the 1986 Act was not intended to alter the tax exempt status, not only for HMOs, but also for "organizations which provide supplemental health maintenance organization-type service (such as dental and vision services) ...if they operate in the same manner as a health maintenance organization."

Assistance is needed from you and your Subcommittee to introduce clarifying legislation specifically naming Vision Service Plan and similar organizations as exempt from the application of IRC section 501(m).

Thank you for your consideration in this matter.

With best regards, I am

Very truly yours,

Robert T. Matsui

ROBERT T. MATSUI
Member of Congress

Mr. KOPETSKI. Ms. Beasley, how would you respond to Treasury's concerns that including organ donor material with refunds might lead to taxpayer confusion in that certain religious groups might object to this?

Ms. BEASLEY. It seems to me that tax refunds have been used as a vehicle to promote various unrelated and perhaps commercial activities. I do believe that the support of the American public for organ donation is sufficient that this would be a reasonably well-received message.

In the Gallup survey we specifically asked people to comment on their religious compatibility with donation or objection to donation. What we learned is that a very small fraction of the American public—only 5 or 6 percent—feel that they have a religious objection to donation.

Certainly the purpose of such an enclosure is not to convey to anyone that they must donate organs, it is to stimulate discussion and to encourage people to make up their minds about that important issue.

Mr. KOPETSKI [presiding]. Have you met with any of the religious group representatives in this town—everybody has a lobbyist, I found out coming here—on this particular issue that there is a Catholic Conference, there is Methodist, the Lutheran, Presbyterian?

Ms. BEASLEY. I have not personally met with those religious leaders. I can certainly provide to the committee, if it would be helpful, some consensus material that comes out of the religious groups commenting on organ donation.

[The following insert comes from "Organ and Tissue Donation: A Reference Guide for Clergy," published by the United Network for Organ Sharing (UNOS) and the South-Eastern Organ Procurement Foundation (SEOPF):]

VI. GENERAL RELIGIOUS BELIEFS CONCERNING ORGAN DONATION AND TRANSPLANTATION

Religion	Transplantation	Donation
Amish	Acceptable if for the welfare of transplant recipient	Reluctant if the transplant outcome is known to be questionable

Discussion:

The Amish will consent to transplantation if they know that it is for the health and welfare of the transplant recipient. They would be reluctant to donate their organs if the transplant outcome was known to be questionable. John Hostetler, world renowned authority on Amish religion and professor of anthropology at Temple University in Philadelphia, says in his book Amish Society, "The Amish believe that since God created the human body, it is God who heals."

However, nothing in the Amish understanding of the Bible forbids them from using modern medical services, including surgery, hospitalization, dental work, anesthesia, blood transfusions or immunization.

Baha'i	Acceptable, if prescribed by medical authorities	Bahaists are permitted to donate their bodies for medical research and for restorative purposes
Buddhist Church of America	Buddha's teaching on the middle path, i.e., the avoiding of the extremes, may be applicable to these points. What is medicine to one may be poison to another. Administering of drugs, depending upon the nature of illness and the individual capacity is of utmost importance. The attainment of enlightment is of prime importance.	This is a matter for individual choice.

Discussion:

The Buddhists believe that organ donation is a matter of individual conscience. There is no written resolution on the issue, however, Reverend Gyomay Masao, President and founder

Religion	Transplantation	Donation
	of the Buddhist Temple of Chicago and a practicing minister says, "We honor those people who donate their bodies and organs to the advancement of medical science and to save lives."	
Christian Scientist	Individual decision	Individual decision
	Discussion:	
	The Church of Christ Scientist takes no specific position on transplants or organ donation as distinct from other medical or surgical procedures. According to The First Church of Christ Scientist in Boston, Massachusetts, Christian Scientist normally rely on spiritual rather than medical means for healing. They are free, however, to choose whatever form of medical treatment they desire, including an organ transplant. The question of organ donation is the individual decision of church members.	
Church of Jesus Christ of Latter-Day Saints	Individual decision	Individual decision
	Discussion:	
	The Church of Jesus Christ of Latter Day Saints (Mormons) made the following policy statement on June 3, 1974; "The question of whether one should will bodily organs to be used as transplants or for research after death must be answered from deep within the conscience of the individual involved. Those who seek counsel from the church on this subject are encouraged to review the advantages and disadvantages of doing so, to implore the Lord for inspiration and guidance, and then to take the course of action which would give them a feeling of peace and comfort."	
Episcopal Church	Persons are encouraged to donate portions of their bodies and to volunteer for transplants only when needed.	No theological objection except that the ultimate disposal of these parts should be done reverently. Use of parts (eye, kidney, etc.) for use in living persons is without any objection; the consent of the donor before death or responsible relatives afterwards would be needed.

Religion	Transplantation	Donation

Discussion:

A resolution passed at the 1982 General Convention of the Episcopal Church stated that: "The Episcopal Church recognizes the life-giving benefits of organ, blood, and tissue donation and encourages all Christians to become organ, blood and tissue donors as part of their ministry to others in the name of Christ, who gave His life that we may have life in its fullness."

Evangelical Covenant Church	Acceptable	Acceptable

Discussion:

A resolution passed at the Annual Meeting in 1982 encouraged the members to "sign and carry Organ Donor Cards." The resolution also recommended "that it become a policy with our pastors, teachers, and counselors to encourage awareness of organ donation in all our congregations."

Greek Orthodox Church	The church has no objection to the use of therapeutic agents, vaccinations, blood transfusions and medical procedures that contribute to the restoration of the health and well-being of the patient.	A decision to donate one's body for medical experimentation or research is not consistent with traditional Orthodox practice and belief.

Discussion:

A spokesperson for the church, the Rev. Dr. Milton Efthimiou, Director of the Department of Church and Society for the Greek Orthodox Church of North and South America, said: "We are not against organ donation provided the organs in question are used for the purpose intended--transplantation--and not for research or experimentation."

Gypsies	Generally opposed	Generally opposed

Discussion:

Gypsies are, on the whole, against organ donation. Although they have no formal resolution, their opposition is

Religion	Transplantation	Donation
	associated with their beliefs about the afterlife. Gypsies believe that for one year after a person dies, the soul retraces its steps. All of the body parts must be intact because the soul maintains a physical shape. According to Matt Salo, a research fellow at the Smithsonian Institute who specializes in gypsy studies, "The gypsies, a set of ethnic groups with a common historical origin, do not have an exclusive religion, but share common folk beliefs which include the sanctity of deceased person's body."	
Hinduism	Acceptable	Acceptable
	Discussion:	
	Hindus are not prohibited by religious law from donating their organs according to the Hindu Temple Society of North America. This act is an individual decision.	
Islam	Acceptable for both donors and recipients. Anything which is considered as medication, treatment, prevention, etc. by a physician as vital to maintain normal health is not only acceptable, but recommended.	Acceptable; no restrictions
	Discussion:	
	The Moslem Religious Council initially rejected organ donation by followers of Islam in 1983; but it has reversed its position, provided that donors consent in writing in advance. The organs of Moslem donors must be transplanted immediately and not be stored in organ banks. According to Dr. Abdel-Rahman Osman, Director of the Muslim Community Center in Maryland, "We have no policy against organ donation as long as it is done with respect for the deceased and for the benefit of the recipient."	
Jehovah's Witness	May be considered acceptable	May be considered acceptable
	Discussion:	
	According to the Watch Tower Society, the legal corporation for the religion, Jehovah's Witnesses do not encourage organ donation, but believe it is a matter for	

Religion	Transplantation	Donation

individual conscience. Athough the group is often assumed to ban transplantation because of its taboo against blood transfusion, it does not oppose donating or receiving organs. All organs and tissues, however, must be completely drained of blood before transplantation.

Judaism — Acceptable — Acceptable

Discussion:

Judaism teaches that saving a human life takes precedence over maintaining the sanctity of the human body. A direct transplant is preferred, however. According to Moses Tendler, Ph.D., an Orthodox Rabbi who is Chairman of the Biology Department of Yeshiva University in New York City and Chairman of the Bio-Ethics Commission of the Rabbinical Council of America, "If one is in the position to donate an organ to save another's life, it's obligatory to do so, even if the donor never knows who the beneficiary will be. The basic principle of Jewish ethics--'the infinite worth of the human being'--also includes donation of corneas, since eyesight restoration is considered a life-saving operation." He adds, "It is given that the donor must be brain dead in accordance with the standards set by the Harvard University criteria and the President's Commission on brain death."

Rabbi Moses Tendler also adds, "We do not feel that there is sufficient reason for organ donation from living persons because of the improved results of transplantation of cadaveric organs that has come about with the new immunosuppressants." Organ donation is actually a "moral obligation," he added. It is the only "mitzvot" or good deed, an individual can perform after death. Rabbi Tendler acknowledged that there is still some reluctance regarding organ donating among Hassidic Jews due to concerns about "defilement of the dead."

Conservative and Reformed Jews may accept brain death more easily than will Orthodox and Hassidic Jews.

Protestantism — Surgical transplants are considered a proper medical procedure — Individual decision

Discussion:

Because of the many different Protestant denominations, a generalized statement on their attitudes toward organ/tissue donation cannot be made. However, the denominations share a common belief in the New Testament. (Luke 6:38 Give to others

Religion	Transplantation	Donation
	and God will give to you.) The Protestant faith respects individual conscience and a person's right to make decisions regarding his or her own body. In addition, it is generally not believed that resurrection involves making the physical body whole again. Lutheran Church-Missouri Synod was the first denomination to encourage donation with a resolution (1981) and the largest distribution of donor cards ever through an issue of Lutheran Witness Magazine. Rev. James W. Rassbach of the Board for Communication Services, Missouri-Synod says, "We accept and believe that our Lord Christ came to give life and came to give it in abundance. Organ donation enables more abundant life, alleviates pain and suffering and is an expression of love in times of tragedy." (See attached resolution.) The United Methodist Church also endorses organ and tissue donation and recognizes the need for "official direction from the church" (see attached resolution).	
Religious Society of Friends (Quakers)	Acceptable; no restrictions. An individual decision.	Acceptable; no restrictions. An individual decision.
Roman Catholic Church	Acceptable Discussion: Catholics view organ donation as an act of charity, fraternal love and self sacrifice. Transplants are ethically and morally acceptable to the Vatican. Ethical and Religious Directives for Catholic Health Facilities, No. 30: "The transplantation of organs from living donors is morally permissible when the anticipated benefit to the recipient is proportionate to the harm done to the donor, provided that the loss of such organ(s) does not deprive the donor of life itself nor of the functional integrity of his body." No. 31: "Post-mortem examinations must not be begun until death is morally certain. Vital organs, that is, organs necessary to sustain life, may not be removed until death has taken place. The determination of the time of death must be made in accordance with current medical practice. To prevent any conflict of interest, the dying patient's doctor or doctors should ordinarily be distinct from the transplant team."	Acceptable
Unitarian Universalist	Acceptable; no restriction when the donor is not harmed, and when the	Acceptable. Again, when the patient and his physicians believe that such operations will

Religion	Transplantation	Donation
	patient and his physician believe that this operation will be of benefit to the patient, we affirm that guidance.	be of benefit to the patient, and when the donor is not harmed, we affirm that guidance

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Additional information provided by the National Kidney Foundation, the New Jersey Organ and Tissue Sharing Network and the Pennsylvania Medical Society.

Ms. BEASLEY. We find that virtually every major Western religion is extremely comfortable with and supportive of donation. That includes the Catholic church; it includes all major Protestant denominations; it includes, as well, Judaism.

In general, there is a very high degree of consensus among religious leaders that organ donation is highly supported or a matter for individual decision. Organ donation is very consistent with most religious philosophies and beliefs.

Mr. KOPETSKI. What has been the most effective method thus far in obtaining organ donations or getting people to sign up?

Ms. BEASLEY. Most organ donor card campaigns are conducted through the departments of motor vehicles. Our research shows that only about 28 percent of the American public reports having signed such a donor card.

Other work performed by the Partnership for Organ Donation inside the hospitals—and you will find some comment on this in my written testimony—indicates that there is a tremendous opportunity to improve organ donation by improving the practices that take place in hospitals.

By this I mean specifically encouraging hospitals to identify every potential donor case and ask the family about donation. We know that this does not happen in roughly a third of the medically suitable cases.

The second aspect is to approach families about donation in a systematic and sensitive manner that respects their needs and gives them time to absorb the shock and tragedy of a death of a family member before asking them to consider donation.

Those two steps, in combination, based on our research, could in fact double the rate of organ donation in this country.

Mr. KOPETSKI. How many States have the driver's license program? I know Oregon does.

Ms. BEASLEY. All but one or two of them do. Most States connect the donor card to the driver's license document itself. There are a small number of States, I believe it is five or six, that have a separate donor card that is also made available at the department of motor vehicle registration.

So, it is nearly universal that organ donor cards are available in motor vehicle departments. One of the issues is that the motor vehicle department is not a place that is particularly conducive to family discussion.

One of the advantages of the proposed legislation is that the message would come into the home in a piece of mail, and family discussions are events that are more likely to take place in the home than in the department of motor vehicles.

Mr. KOPETSKI. Do you have any estimates on the effectiveness of this proposal if we were to enact this?

Ms. BEASLEY. What we do know from the survey results is that when family members know one another's wishes, they are overwhelmingly inclined to comply. As I mentioned in my testimony, when there has been communication that a family member wishes donation, 93 percent of the public say they would respect that. If there was no such discussion, only 47 percent say that they would opt for donation.

What we also know from the survey is that only about half of the people who say they support organ donation and wish to be a donor have, in fact, communicated those wishes to their families.

So we view this as a very real opportunity to increase communication and, thereby, increase consent for donation.

Mr. KOPETSKI. Thank you. Thank you for your testimony and also for being patient, given the hour.

Mr. Udstuen, the Treasury Department has testified that it would not support the use of composite discount factors for tax years before 1994.

Treasury also indicates that they would prefer to see this and other medical malpractice issues resolved in the context of comprehensive health reform.

How do you respond to this?

Mr. UDSTUEN. I think that is great, Mr. Chairman. And this committee will have a lot to do with comprehensive tax reform or health care reform.

At the point we get to national health care reform, we are willing to live with what is passed through this committee and I am sure through the Congress.

What I am asking you to do is help us get to that point, wherever that is down the road, so that we can start at an equal basis when we move ahead to that.

Treasury's position is kind of mixed on this. It is very unclear. I think they realize the problem, and I think they are concerned. This is a very limited group. It is medical malpractice companies in the physician marketplace that are really looking for this.

So if you pass tax changes when you pass health care reform, we have to live with that, terrific, Mr. Chairman. But get us to that date.

Mr. KOPETSKI. OK. Ms. Davis, your written testimony describes how you could minimize or eliminate your U.S. tax liability through the formation of an offshore captive. I am wondering whether you are aware of other organizations that have taken advantage of this loop hole?

Ms. DAVIS. It is my understanding that it has mostly been used by hospitals. I am not an expert on that. Our tax person has looked into it. And it is only available for organizations that are exempt themselves as 501(c)(3) organizations and own the company.

Mr. KOPETSKI. So, let's see. Why haven't your organizations taken advantage of this?

Ms. DAVIS. I guess it is because——

Mr. KOPETSKI. Most of your members are 501(c)(3) organizations?

Ms. DAVIS. They all are. They are all 501(c)(3). The reason is that we really need tax exempt 501(c)(3) status to raise money from foundations because we don't have any other source of permanent capital.

And that has really been the key focus. It is not really avoiding tax that has been the big issue for us. We just don't have any source of permanent capital except through foundations.

Mr. KOPETSKI. I understand that Treasury would not oppose legislation to allow your organization to qualify as a tax-exempt organization, provided the organization receives a sufficient amount of contributions from nonmembers.

Ms. DAVIS. Right.

Mr. KOPETSKI. And that such contributions are used to subsidize the cost to members.

Would your organization be able to meet these conditions?

Ms. DAVIS. All of the $1.3 million that we used for our startup as provided by foundations in the form of program-laden investments. Those are 2 percent loans which are highly subordinated.

That's the only kind of money we could get from foundations because our tax status was so undetermined.

Mr. KOPETSKI. I see. OK.

Mr. Reynolds I did have some questions, and we have got some debate going on on the Floor on our appropriations bill.

And I think, Mr. Udstuen, he had some questions for you. May I ask that we may send you a letter asking you to respond to those questions for the record.

If so, we will make certain that they are a part of this committee testimony and record.

Mr. UDSTUEN. That would be appreciated, Mr. Chairman.

Mr. KOPETSKI. And I thank all of you, again, for your patience, especially given the hour.

The committee is adjourned.

[Whereupon, at 5:20 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of
RICHARD M. DALEY
MAYOR
CITY OF CHICAGO
in support of
HR 737, STRICT LIABILITY FOR SAFER STREETS ACT OF 1993

I submit this statement in support of H.R. 737, legislation introduced by Rep. Mel Reynolds that would hold manufacturers and importers of certain firearms strictly liable for damages that result from use of that firearm and increase the excise tax on firearms to assist urban hospitals that provide much of the care to gunshot victims. I applaud Rep. Reynolds for introducing this bill and urge Congress to enact H.R. 737 without delay.

Like many other parts of the country, Chicago has been hit with an epidemic of handgun violence. The easy availability of deadly weapons has turned minor disagreements into fatal showdowns. Last year 937 people were murdered in the City of Chicago, more than 70% of those had been shot. But the homicide statistics in Chicago and across this country are only the tip of the iceberg. As tragic as each homicide is, in actuality, thousands more are injured by firearms each year in the City of Chicago, straining the staff and the resources of the struggling Chicago trauma centers. In 1992, 2500 individuals were treated for gunshot wounds in Chicago area trauma centers. Today's newer, more powerful rapid-fire weapons of choice, are more accurate and more deadly. Many of those injured are permanently disabled. The figures relative to the medical care associated with these disabilities are staggering.

Lawrence J. Gorski, Director of the City of Chicago's Office for People with Disabilities, laments that the ever-increasing number of gun related disabilities will only further deplete the financial resources of our nation's health system. America spent approximately $14 billion treating gun related injuries in 1992. And that is just for hospital care and rehabilitation. It doesn't include the lifelong costs of lost wages, financial assistance programs such as SSI, public aid and medicaid, and ongoing medical and rehabilitation services. For example, it has been estimated that the lifetime cost of treating a person with a severe spinal cord injury can range from $3 million to $5 million. The average cost of treatment for a gunshot victim at a Chicago trauma center is over $16,000. Over 80% of those costs are borne by the tax payer. The metropolitan area of Chicago has more than one million people with disabilities. Quite frankly, Mr. Gorski does not need any more customers.

Money that could be spent improving the health of pregnant mothers, infants, and school children, treating people for substance abuse, or searching for a cure to AIDS, cancer and heart disease - is spent treating gunshot victims. Money that could be spent on countless worthy causes to address severe needs like job training, better housing, day care, and Head Start - is consumed by a vast law enforcement effort to get guns out of the hands of criminals.

How do we fight this situation? The City of Chicago has some of the strictest regulations in the country on guns. Our Chicago Police Department confiscated over 22,000 firearms in 1992, more than any other city. The Police Department has joined with the Bureau of Alcohol, Tobacco, and Firearms and Chicago Revenue Agents to crackdown on federally licensed firearm dealers operating from their homes. Despite an aggressive police department and tough, local ordinances restricting the ownership and possession of handguns, the slaughter continues in our streets. It is time to go after those who profit from the terrible bloodshed and heartaches these weapons create.

For too long, the gun control debate has focused on individual rights instead of responsibility. Americans have somehow been afraid to point a finger at the source of the problem. For too long, the gun lobby has misled the Congress and diverted your attention from those that are accountable. The gun manufacturers and importers have had a free ride while their products have caused injury and death at an alarming rate.

Whatever happened to the concept of industry responsibility? And why have the gun manufacturers escaped this obligation to the American people? What about the fly-by-night companies that are making millions of dollars selling guns on our streets. These guns are often marketed like toys and aimed at children. The advertisement of the Tec-9 semi-automatic - a favorite of gang members - says "Only your imagination limits your fun." I find that morally offensive. A manufacturer of a weapon that can fire 30 rounds in three seconds clearly knows and understands that such guns have no other purpose than to kill people. It is surely not unreasonable to ask the law to require those who profit from unreasonably dangerous products to pay for the harm they cause. Right now, gun manufacturers simply have no reason to invest in safety or worry about the epidemic of gun violence across America. I, therefore, strongly support the provisions of H.R. 737 that would make manufacturers and importers of firearms strictly liable for damages that result from use of these firearms.

I also support the provisions of H.R. 737 that would implement a tax on the sale of guns and ammunition. Gun buyers and owners should help society recover some of the $14 billion dollars we spend each year treating gunshot victims. Today, Chicago's trauma network is falling apart. There are fewer and fewer hospitals that can treat gunshot victims, and because the weapons are more powerful, the wounds are far worse.

While those in the urban areas may suffer the worst, this is not a problem that is unique to large cities. More and more gun violence has spread to suburban and rural areas. It will continue to do so. You can rest assured that the gun manufacturers will not solely target larger metropolitan areas when they seek to sell their weapons.

You must not close your eyes or turn your backs on the more than 20,000 individuals lives snuffed out every year from gunshot wounds. Must we continue to lead the world in the number of young people killed by guns? Should 14 children continue to perish daily from gun violence?

There are over 200 million guns today in the United States. Do we allow this number to continue to spiral along with the resultant injury and death toll? Isn't it time we looked to the manufactures and importers of these weapons and said you have escaped responsibility for far too long. Let us strike a real balance between rights and responsibility - so we can save both money and lives while fostering a safer and less violent society.

The P • I • E Mutual Insurance Company

June 30, 1993

The Honorable Charles B. Rangel
Chairman, Subcommittee on Select Revenue Measures
Committee on Ways and Means
1105 Longworth HOB
Washington, DC 20515-6350

IN RE: Proper Method of Loss Reserve Discounting For Medical Malpractice Insurance Companies

Dear Chairman Rangel:

The purpose of this letter is to provide written testimony in support of the proposal by Representative Mel Reynolds to clarify the Congressional intent with respect to the proper method of loss reserve discounting for medical malpractice insurance companies.

We believe that the current loss reserve discounting methodology imposed on a medical malpractice insurance company adversely affects national health care policy. The current loss reserve discounting rules in effect unnecessarily force increases in medical malpractice insurance rates. These increases are ultimately passed on by the physicians to the consumer at a time when the administration is attempting to get our nation's health care costs stabilized or reduced.

I am Howard Friedman, Senior Vice President-Actuary for The P·I·E Mutual Insurance Company located in Cleveland, Ohio. The Company is one of the largest writers of medical malpractice insurance in the United States, insuring more than 15,000 physicians in nine states.

Unlike many lines of insurance, medical malpractice insurance is provided through a choice of an occurrence or a claims-made policy form. The occurrence form provides coverage for all claims which arise from a given year of medical practice regardless of when the claim is reported. Claims-made policies provide coverage for claims reported only during the policy year. The advantage of the claims-made policy is that the insurer knows how many claims are reported for any policy year, thus making the pricing of the policy much more certain.

North Point Tower 1001 Lakeside Avenue Cleveland, Ohio 44114-1149 216-736-8400 800-228-2336

The relative actuarial certainty inherent in the claims-made policy provides a financial advantage and therefore many medical malpractice insurance carriers either switched to this form of coverage during the 1980s or began using it from inception.

For the same reasons, the major reinsurance companies indicated during this period that the claims-made form was the form of preference. The actuarial certainty within the claims-made policy enabled the reinsurance companies, which all medical malpractice insurance companies use, to better price the reinsurance treaties. The resultant lower costs could then be passed on to the medical profession in lower premiums.

At the same time a number of companies were switching to the claims-made form, the Tax Reform Act of 1986 (The Act) was passed. Among the provisions of The Act was a provision which required property and casualty insurance companies to discount their loss reserves beginning in 1987. The purpose of the discounting requirement was to restrict overstating loss reserves and thereby require companies to pay tax on their economic income.

The Act specified that insurance companies had to discount their loss reserves using either industry payment patterns, published by the IRS, or using their own historical patterns. Since most of the medical malpractice coverage written prior to the passage of The Act was on an occurrence basis, the industry factors published by the IRS were on an occurrence basis. However, by this time the majority of the medical malpractice carriers were writing on a claims-made basis.

Although companies were allowed to discount their loss reserves utilizing loss payment patterns based on their own historical experience, this experience was not representative of the payment patterns for the type of business they were currently writing (i.e. they had switched from the occurrence form to the claims-made form). Consequently, the amount of income taxes payable to the IRS by these companies was artificially increased.

In 1991, in response to this issue, the IRS issued Revenue Procedure 91-21. This revenue procedure allowed an insurance company writing medical malpractice insurance coverage to elect to use the "Composite Schedule P" experience in discounting its loss reserves. The rationale for allowing the Composite Schedule P factors to be used was that the payment factors associated with claims-made business were more reflective of the Composite Schedule P experience. This Revenue Procedure expired in 1991. The Revenue Procedure's expiration date was unreasonably short and left many companies without having the requisite claims-made experience to create a meaningful payment pattern.

The release of Revenue Procedure 92-76 and the final regulations under Section 846 of the Act created an unfair tax burden being placed on medical malpractice insurance carriers which Revenue Procedure 91-21 had addressed. It is important to note that Revenue Procedure 92-76 was not issued until September 1992 and was effective retroactively to January 1992. Since many medical malpractice insurance companies did not anticipate this problem, they were unable to take steps to deal with the resultant tax increase which occurred. Consequently, they are now being forced to raise medical malpractice insurance rates in order to maintain acceptable statutory surplus levels which were reduced after paying the increased taxes. In addition to increasing the tax burden of existing companies, these new rules effectively prohibit new companies from forming due to the resulting need for higher capital/surplus.

Another important negative result from Revenue Procedure 92-76 is the "unleveling" of the playing field among medical malpractice insurers. Similarly situated medical malpractice insurers are being taxed very differently because of the timing of a business decision, i.e. claims' made as opposed to occurrence issued policies, made prior to a change in the law. This allows certain companies to have a significant competitive edge over other similar companies as a result of the tax issue at hand. These consequences are neither necessary or sensible. The only practical solution to this problem is for the IRS to restore the effect of Revenue Procedure 91-21 for tax years 1992 and 1993 and to issue separate claims' made discount factors for subsequent years. These factors should be compiled and released as soon as possible and not force companies to overpay their income taxes for the next five years (i.e. the next determination year).

The proposal submitted by Representative Reynolds provides transitional relief to these companies until such time as the Treasury can release discount factors on both an occurrence and a claims-made basis. This proposal would allow companies to pay tax on their "economic" income as opposed to an unjustified, unrealistically inflated income. This proposal will, in addition to providing relief from an unfair and burdensome tax, provide some relief from increasing medical malpractice insurance rates which in turn will assist in mitigating the increasing cost of health care.

I appreciate the opportunity to provide you the above written testimony in support of the proposal by Representative Mel Reynolds to clarify the Congressional intent with respect to the proper method of loss reserve discounting for medical malpractice insurance companies. If you have any questions regarding my above presentation or if you require any additional testimony, please feel free to call upon me.

Very truly yours,

Howard H. Friedman
Senior Vice President-Actuary

HHF/ff

TESTIMONY OF

TOM WOODRUFF
PRESIDENT OF
DISTRICT 1199 WEST VIRGINIA/KENTUCKY/OHIO
HEALTHCARE AND SOCIAL SERVICE WORKERS UNION
SERVICE EMPLOYEES INTERNATIONAL UNION
HUNTINGTON, WEST VIRGINIA

My name is Tom Woodruff. I am president of District 1199 West Virginia/Kentucky/Ohio -- the Healthcare and Social Service Workers Union. District 1199 represents 12,000 workers in the tri-state area who work in healthcare facilities and social service agencies in both the public and private sectors. The membership includes professionals, paraprofessionals, technical and service and maintenance workers.

I am grateful to Chairman Rangel and the other members of the subcommittee for this opportunity to express the concerns of the members of my union about the hazard of bloodborne infection through needlestick injuries.

Needlestick injuries are not restricted to just one occupation. Unprotected needles represent a hazard not only to the user of the device, but also to so-called downstream workers like housekeepers and laundry workers. Let me give some examples.

Pat Salyers is an LPN at the Highlands Regional Medical Center in Prestonburg, Kentucky, where District 1199 represents 320 workers. One day about three years ago, Pat was dismantling an IV set-up and preparing to dispose of it. Three used needles had been left hanging in the administration set. All three fell out and stuck her at the same time. Just last fall, Pat was stuck again while administering an injection.

District 1199 also represents service and maintenance workers at the Kings' Daughters Medical Center in Ashland, Kentucky. We have identified seven housekeeping workers who have been stuck by used needles.

Paula Brainard was picking up the garbage in the lab and was stuck by a hypodermic needle that had been improperly disposed of. Barb Colley was stuck while collecting trash in a labor and delivery room.

About two years ago, Joe Caudill and Linda Johnson received needlesticks and both have contracted hepatitis B. Linda has developed a form of arthritis as a result of her treatment for HBV.

While Dorothy Ratliff was removing the sheets from a patient's bed one day, a used needle fell to the floor. Dorothy stepped on it and was stuck through her shoe. Housekeepers Patrick Layne and Kelli Deboard are two other District 1199 members who have received needlestick injuries.

Every needlestick is a traumatic event for a worker, because they don't know whether or when they will become infected with a serious disease like hepatitis B or HIV.

Better disposal methods aren't the solution. The real solution lies in re-engineering medical devices so that they do not present a hazard after use.

It's time for the federal government to use its power to curb the use of unsafe needle-bearing devices. H.R. 1304 will require the Food and Drug Administration to do just that by developing performance safety standards for devices with needles.

On behalf of the 12,000 members of District 1199 WV/KY/OH, I would like to thank Chairman Rangel for holding this hearing on safe medical devices. We need to take care of the people who take care of us.

STATEMENT OF VISION SERVICE PLAN

The following statement is made by Vision Service Plan, a California non-profit corporation, for inclusion in the printed record of the hearing on the tax treatment of health maintenance organizations to be held on June 29, 1993.

Section 1012 of the Tax Reform Act of 1986, P.L. 99-514, enacted new Internal Revenue Code section 501(m). New section 501(m) provides that, in general, organizations which devote a substantial part of their activities to providing commercial-type insurance are ineligible for tax exemption. Section 1012(c)(4)(C) of the Tax Reform Act of 1986 provides, in part, that "the amendments made by this section shall not apply to - ...(iv) dental benefit coverage provided by Delta Dental Plans Association through contracts with independent professional service providers so long as the provision of such coverage is the principal activity of such Association." Vision Service Plan has contended and continues to contend that the exemption of Delta Dental Plan from the application of Internal Revenue section 501(m) is an acknowledgment that the dental services provided by Delta Dental Plan are not commercial-type insurance within the meaning of Internal Revenue Code section 501(m). Prior to the passage of the Technical Corrections and Miscellaneous Revenue Bill of 1988, the support for our contention was found in the Conference Committee Report on the Tax Reform Act of 1986 which stated, "Organizations that provide supplemental health maintenance organization-type services (such as dental services) are not affected if they operate in the same manner as a health maintenance organization." (House Conference Report, No. 99-841, pg. II-345.)

The passage of the Technical Corrections and Miscellaneous Revenue Bill of 1988 confirmed that new Internal Revenue Code section 501(m) does not apply to HMO-type organizations which provide vision services. Press Release No. 31-A of the House Ways and Means Committee issued on July 15, 1988, in Part Three in the section labelled B.3, on page 4, states as follows:

> "the Committee agreed to clarify that the language in the Ways and Means Committee Report for the Tax Reform Act of 1986 would not be overridden by the Statement of Managers to the Conference Report for that Act. The Committee also clarified that dental and vision care is a type of supplemental HMO-type service contemplated by the 1986 Act legislative history. The provision would be effective as if included in the 1986 Act." (Emphasis Added)

Subsequently, the House Ways and Means Committee Report on H.R. 4433 (the Technical Corrections and Miscellaneous Revenue Act of 1988), reported on July 26, 1988, in Title I, in the section labelled X.2, on page 115, states, in part, as follows:

> "Organizations that provide supplemental health maintenance organization-type services (such as dental or vision services) are not treated as providing commercial-type insurance if they operate in the same manner as a health maintenance organization." (Emphasis Added)

The Senate Finance Committee Report on S. 2238 (the Technical Corrections Bill of 1988), filed on August 3, 1988, in the section labelled X.2, on page 144, states as follows:

> "organizations that provide supplemental health maintenance organization-type services (such as dental or vision services) are not treated as providing commercial-

> type insurance if they operate in the same manner as a health maintenance organization (HMO). HMOs provide physician services in a variety of practice settings primarily through physicians who are either employees or partners of the HMO or through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis)." (Emphasis Added)

Finally, the Conference Report on the Technical Corrections and Miscellaneous Revenue Act of 1988, H.R. 4433, the Statement of Managers, released October 24, 1988, on page 11 in a section labelled "Insurance," states, in part, as follows:

> "Under the 1986 Act, the provision relating to organizations engaged in commercial-type insurance activities did not alter the tax-exempt status of health maintenance organizations (HMOs). HMOs provide physician services in a variety of practice settings primarily through physicians who are either employees or partners of the HMO or through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis). The Conference Agreement clarifies that, in addition to the general exemption for health maintenance organizations, organizations that provide supplemental health maintenance organizations-type services (such as dental or vision services) are not treated as providing commercial-type insurance if they operate in the same manner as a health maintenance organization." (Emphasis Added)

It is clear that Vision Service Plan is an organization that provides "supplemental health maintenance organization-type services," namely, vision services. It is the clear intent of Congress that the activity of Vision Service Plan not be treated as providing commercial-type insurance.

Further, Vision Service Plan operates in the same manner as a health maintenance organization. For instance, Vision Service Plan:

> 1. Provides services for payments on a periodic basis fixed without regard to frequency, extent or kind of services required, as does an HMO.
>
> 2. Contracts with individual eye-care providers as an HMO contracts with physicians.
>
> 3. Makes services available with reasonable promptness in a manner that assures continuity, as does an HMO.
>
> 4. Operates in a fiscally sound manner under sound administrative and managerial arrangements, as does an HMO.
>
> 5. Assumes full financial risk for the services provided and assures that members will not be liable for services rendered under the plan, as does an HMO.
>
> 6. Provides that a member will not be expelled or refused re-enrollment because of health status or the

services needed, as does an HMO.

7. Provides representation of members on an advisory board, as does an HMO.

8. Provides procedures for hearings to resolve disputes between Vision Service Plan and members, as does an HMO.

9. Contains a quality assurance program, as does an HMO.

10. Provides utilization review and cost review, as does an HMO.

11. Provides for the confidentiality of the provider/patient relationship.

Since Vision Service Plan provides vision services, an HMO-type service, and operates in the same manner as an HMO, it is clear that Congress intended that Internal Revenue Code section 501(m) be inapplicable to Vision Service Plan, and Vision Service Plan should be entitled to recognition of its exempt status under Internal Revenue Code section 501(c)(4) just as it would have been eligible prior to the enactment of new Internal Revenue Code section 501(m).

However, notwithstanding the fact that it was clearly the intent of Congress that organizations which provide supplemental health maintenance organization-type services (such as dental or vision services) should not be treated as providing commercial-type insurance, the Internal Revenue Service continues to refuse to grant Vision Service Plan's application for exemption recognition. The chief counsel's office of the Internal Revenue Service has issued General Counsel Memorandums (GCMs) 39828, 39829, and 39830. GCM 39829 seems to summarize the position of the IRS in concluding that an HMO whose contracts with doctors provide for the payment of all services on a capitated basis, does not lose it's exemption under IRC section 501(c)(4) by operation of IRC section 508(m). Apparently, the IRS views capitated HMOs as those that were in existence in 1986 and therefore, the only target of exclusion from IRC section 501(m) as enacted by the Tax Reform Act of 1986.

Vision Service Plan respectfully requests that this Subcommittee support efforts to introduce and pass clarifying legislation, specifically granting Vision Service Plan, and similar organizations, exemption from the application of IRC section 501(m).

Statement for the Subcommittee on Select Revenue Measures
Committee on Ways and Means,
U.S. House of Representatives
June 29, 1993

Prepared by: Audrey Harrison
Risk Manager
Watts Health Foundation, Inc. dba United Health Plan

This statement is in support of an amendment to the Internal Revenue Code to clarify the status of the Nonprofits' Insurance Alliance of California (NIAC) as an organization exempt from tax under Section 501(c)(3).

The predecessor organization to the Watts Health Foundation, Inc. dba United Health Plan (WHF) was formed in 1967 to provide health care services to residents of the community located in South Central Los Angeles, California. It provides various health care services including radiology, adult medicine, pediatrics, physical therapy, pharmacy, dental and prenatal care. In 1976, WHF formed a federally qualified health maintenance organization, United Health Plan, which provides outpatient services to more than 50,000 residents of South Central Los Angeles. WHF's other programs include House of Uhuru inpatient substance abuse programs, and counseling center for substance abuse problems. Its Geriatrics and Homebound Services provides transportation to and from its center where recreation, counseling and nutritional services are provided to seniors. NIAC provides general liability coverages for WHF and will begin providing auto coverages next month. NIAC does not provide medical malpractice coverages.

WHF has experienced the dramatic market fluctuations that can create havoc with the continuity of operations of an organization like ours. Because of the extreme insecurity we felt with the commercial insurance market, WHF sought out a secure and stable carrier which would help us fund for liability claims with a fair and predictable premium price over time. Nonprofits' Insurance Alliance of California (NIAC) has provided that stability for us.

There are many benefits to WHF from being a member-insured of NIAC. NIAC specializes in resolving coverage problems for the unique needs of organizations such as ours. By following prudent and conservative management and investment practices, NIAC is able to provide low-cost prices which are stable over time and not subject to the unpredictable price changes to which we are subject in the commercial insurance marketplace.

The fact that NIAC's assets are irrevocably dedicated to the charitable nonprofit sector in California is a key factor in assuring that coverage will be available longterm for WHF. With commercial carriers, WHF was always vulnerable to insurer restructuring or changing priorities or diminished capacity during hard market periods. We could never be sure from one year to the next whether coverage would be available, or if available, if it the cost would be prohibitive. If a nonprofit faces a financial disaster resulting from an uninsured loss, it is a double tragedy. The nonprofit collapses and the community loses an important resource.

Commercial insurance carriers simply do not understand the unique aspects of the risks associated with nonprofit organizations and the diverse communities they serve. Many of the services provided by nonprofits involve a large human service component, and are difficult for insurance underwriters to quantify. Because of this difficulty in reducing the calculated risk of these diverse services to an annual premium, there is a large component of subjective judgement in the underwriting of these types of risks. It is commonly understood that insurance underwriters who are unsure of the scope of a risk, will usually include a "fudge factor" in the price to cover for the unknown. It works to nonprofits advantage to work collectively through a mechanism like NIAC where each nonprofit member can pay a premium that most accurately reflects the risk associated with its activities.

In addition to providing low-cost coverages, NIAC offers claims administration that is mindful of the diverse and complex communities their members serve. They also provide us with professional assistance to help with safety and loss control issues.

Finally, as an elected member of NIAC's board of directors, I have a voice in the affairs of the company and an opportunity to participate in the decision making process that will insure NIAC's continued stability and ability to serve nonprofit organizations such as ours.

I urge you to clarify NIAC's tax exempt status under 501(c)(3) so that charitable nonprofits may continue to provide badly needed services to our communities without the constant threat of losing affordable liability insurance coverage.

Statement by

The Wildlife Legislative Fund of America

The Wildlife Legislative Fund of America (WLFA) is opposed to The Firearms Victims Protection Act (H.R. 2276 and S. 868) because it represents a misuse of funds originally set aside for sportsmen.

WLFA is an association of sportsmen-conservation organizations established to protect the heritage of the American sportsman to hunt, fish and trap. Through its associated organizations, WLFA represents an aggregate membership of more than 1.5 million sportsmen-conservationists, many of them in California.

In 1937, Congress, with the support of sportsmen, established a ten percent excise tax on rifles, shotguns and ammunition (handguns were added in 1971). This law is commonly known as "P-R" for Pittman-Robertson and formally known as the Wildlife Restoration Act of 1937. In 1975, again with the support of sportsmen, the levy was raised to eleven percent and the law was amended and expanded to encompass archery equipment and a portion of the revenues were channeled to support hunter safety training and range development. P-R funds are deposited into the Federal Aid to the Wildlife Restoration Fund managed by the Department of the Treasury. Amounts in the Wildlife Restoration Fund are allocated to State fish and game agencies to support wildlife restoration and "comprehensive fish and wildlife resources management plan(s) which shall ensure the perpetuation of these resources for the economic, scientific and recreational enrichment of the people."[1] "The term 'wildlife-restoration project' shall be construed to mean and include the selection, restoration, rehabilitation and improvement of areas of land or water adaptable as feeding, resting or breeding places for wildlife...."[2]

The support for these programs has come from the knowledge that the money was placed in trust and used to help pay for the acquisition and management of wildlife areas and related programs for the benefit of present and future Americans.

According to the Wildlife Management Institute (WMI) P-R funding represents 75% of the average budget for state wildlife management.

Simply put, The Firearms Victims Protection Act represents a misuse of the P-R Trust Fund since it will substantially reduce the amount of money States are able to budget for wildlife restoration and divert those funds to use the proceeds from those increases to pay for medical care for gunshot victims.

While WLFA certainly regrets the increase in gunshot victims, we do not believe sportsmen should be forced to pay this additional tax to pay for the acts of criminals. P-R is a successful program at both the federal and State levels and any attempts to divert funds from this important trust fund should be strongly opposed by members of this committee.

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[1] 16 U.S.C. %%669 e.

[2] 16 U.S.C. 669a.

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