HEALTH CARE CONSUMER

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Consumer activist Ralph Nader gave the keynote address at CCHCC's Annual Conference and Awards Dinner on April 29 at the Illini Union. Photo by John Dixon

Nader Urges Consumer Activism

In an impassioned speech culminating CCHCC's Twelfth Annual Conference, consumer advocate Ralph Nader challenged CCHCC members to disseminate our knowledge and expertise nationwide, and to link up with other consumer organizations through computer networks and fax systems, so that we can begin to challenge "the concentrated pockets of power that control our health care system."

Nader told the three hundred plus people gathered in the Illini Union for CCHCC's Awards Dinner that the roots of the problems in America's health care system lay in the fact that the health industry has completely dominated health policy to the exclusion of consumer interests. "Our country needs to get to the point where the power is balanced, like the scales of justice, between consumers and health professionals," Nader said.

"The irony," Nader continued, "is that we have the knowledge to immediately improve the health care system." Study after study has shown in great detail specific areas where

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Consumers Grow Wary of HMOs

Health maintenance organizations were touted in the early 1980s as a means to cutting health costs, promoting preventive care, and ensuring that virtually all medical costs would be covered by one monthly premium. An example of the enthusiasm is an article appearing in the November 1983 Parent's Magazine:

"Last year, Sue Adams gave birth to an eight pound boy. During their sons's first year, she and her husband, Rick, took him to the pediatrician eight times -- six times for regular well-baby checkups, which included immunizations and weight and measurement checks; and twice more to take care of a middle ear infection the baby developed following a cold. Sue and Bill never received a medical bill, nor are they likely to receive one for future visits."

In contrast to this optomistic, laudatory tone of just a few years ago, HMO consumers now report extensive and nontrivial copayments for regular visits to the doctor (a key to the preventive aspect), for emergency room care, for hospital admissions, and for outpatient mental health care. In addition, premiums have

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systematically increased and coinsurance requirements have been added. Other current complaints about HMOs include unfair or discriminatory eligibility requirements, lack of availability of primary care

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Campaign for Women's Health Care emerges from debate over services

For many, the controversy surrounding the merger of Burnham and Mercy Hospitals ended last February when the City of Champaign and Mercy's parent corporation, ServantCor, signed a Memorandum of Understanding (MOU) to merge the two hospitals. But for local residents concerned with reproductive services, the signing of the MOU offered few assurances that these services wouldn't be significantly curtailed. Determined to see that the issue of reproductive services wouldn't be lost in the 'euphoria' surrounding the signing of the MOU, local activists representing a variety of women's and citizens' groups established the Campaign for Women's Health Care.

After several preliminary discussions, the Campaign identified "the leasing of space at Burnham for the continuation of reproductive services" as its top priority. Under the MOU, space could be leased for the provision of health care services that the new Catholic hospital would not provide. However, once the Master Consolidation Agreement is signed, the Catholic Church, which is philosphically prohibited from providing reproductive services, would have to approve any leasing arrangements. Therefore, the Campaign sought to have the lease in place before the signing of the Master Consolidation Agreement.

In addition to the lease, the Campaign also targeted policies concerning the provision of information about reproductive services to patients at the new institution, and the treatment of rape victims at both the new institution and Carle Hospital. Concerns over Carle arose when it was learned that Carle Hospital was billing rape survivors for sevices, something that is prohibited under state law.

To kick off its efforts, the Campaign organized a public meeting with Mayor Dan McCollum on April 17. At that meeting, CCHCC Board member and Campaign representative Imani Bazzell presented the Mayor with these demands:

1) Convene a meeting of Christie, independents, and women's groups to discuss specific options for reproductive services after the merger;

2) Request the Interim Board of the new hospital to exclude a limited amount of space from the lease with ServantCor in anticipation of the provision of health services; and

3) Instruct the city's representatives on the Interim Board to push for the development and issuance of policies regarding the treatment of rape victims and informed consent as it pertains to reproductive services at the new institution.

Although the Mayor balked at agreeing to any of the three requests, he did agree to use the influence of his office to assure the Campaign had access to the "institutional players" who would be ultimately responsible for these decisions.

With the issue of reproductive services back in the public limelight, a flurry of meetings began to take place. Campaign representatives made presentations to independent physicians, the Transition Board of the new hospital, and the Burnham Board of Directors. At the same time, several more meetings were held with the Mayor and hospital employees working on the merger agreement.

The first major breakthrough didn't occur until late May at a meeting with Christie officials. At that meeting, Christie CEO Bob Thompson informed Campaign representatives that Christie Clinic was ready to sign a lease with Burnham Hospital for the provision of reproductive services. The announcement was the first indication that a lease could be finalized before the merger.

"We are hopeful that the lease can be finalized," explained Bazzell, "but we won't be satisfied until we see it in writing. There is still the issue of costs, but we remain hopeful."

At present the Campaign is seeking the following actions from each of the key institutional players:

The Transition Board should develop policy on dissemination of information regarding services they do and do not provide; policy on sharing of information between outside service providers and patients; service contract with Rape Crisis Services; mechanism for public input.

The Burnham Board/City of Champaign should finalize plan for leasing of Burnham space for the provision of reproductive services before the Master Consolidation Agreement is signed.

Christie Clinic should work with Burnham and independent physicians to lease space for reproductive services.

Carle Hospital and Clinic should enter into a service contract with Rape Crisis Services, and assess, with consumer input, the accessibility of their services given the changing health care environment.

HMOs: Medical Reform or Marketing Ploy?

Panelists

Tom O'Rourke
Professor, Health Studies
University of Illinois

Richard Perry
President and Founder
Patient Account Services

Hank Scheff
Director, Budget & Benefit Analysis
AFSCME, Council 31

Gerry Tresslar
Executive Director
CarleCare HMO

MONDAY JUNE 26 7:00 PM

Champaign Public Library Auditorium
505 S. Randolph

Admission is **FREE**

Approximately 200 faithful Bingo players attend one of CCHCC's two annual Bingos. This will be the first year for our new Freedom Bingo Celebration, to be held on July 3 at the Moose Lodge in Champaign.

Bingo Bash

CCHCC is having its First Annual Freedom Bingo Celebration on July 3, 1989. The event will be held at the Moose Lodge in Champaign at 124 W. White Street. No reservation is needed.

The doors will open at 5 PM, when we will begin selling bingo sheets and supplies. The first game will begin at 7 PM. There will be two $500 jackpots, and all other games will have $100 jackpots. A $50 doorprize will also be awarded.

So don't forget to mark your calendar and come to our Freedom Bingo Celebration on Monday, July 3, 1989.

See you there!

League of Women Voters:
Doctors Discriminate Against Medicaid Patients

If you live in the Charleston or Mattoon areas and you are on Public Aid (Medicaid), don't get sick. That was the conclusion of a recent study conducted by the Coles County League of Women Voters. The study surveyed the nearly 60 area doctors and found that 97% of them refuse to accept any new Medicaid patients, even though they continue to accept other new patients.

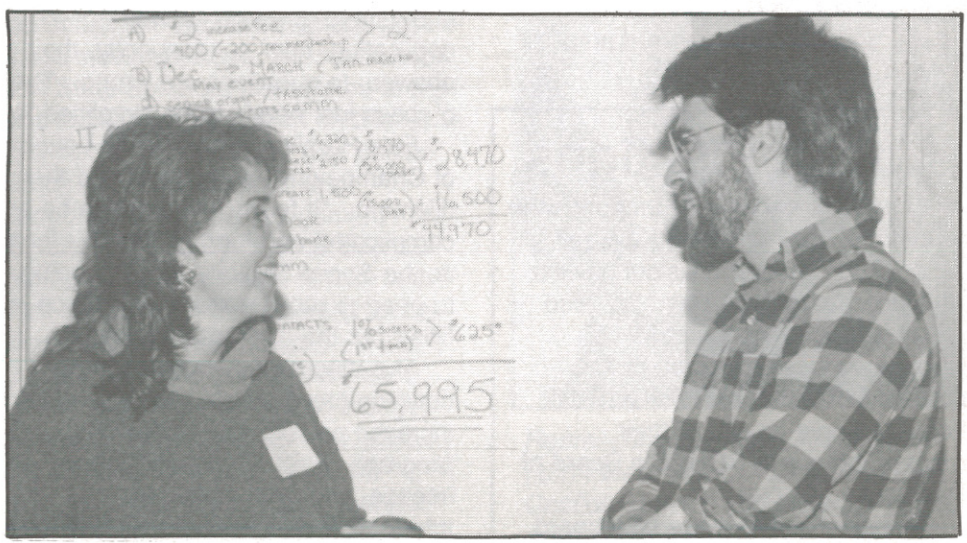
The League's study also found that many rural counties are not adequately staffed with doctors. Although Coles County has more people and doctors than any of the counties that surround it, ironically it is easier for public aid recipients to receive medical care in the more rural counties than in Coles County. "I think the Hippocratic Oath that they're going to provide health care to everybody has been lost somewhere," commented Judy Moll, then Chairwoman of the League of Women Voter's Health Care Costs Committee, at the press conference releasing the results.

This study raises some important questions about discrimination against Medicaid patients. In 1986 CCHCC filed a class action complaint against Carle Hospital because it discriminated against Medicaid patients from outside Champaign County. After months of denying CCHCC's charges, Carle eventually capitulated in February of 1987, when it signed a consent decree stating it would accept Medicaid patients from five neighboring counties.

At that time, CCHCC argued that Carle actually served a much larger region, encompassing Coles and 40 other counties. CCHCC argued that Carle's policy placed an unfair financial burden on local providers by skimming off paying patients, leaving the local providers to serve the poor. CCHCC predicted that eventually other local providers would also turn to discriminatory practices in an effort to better compete with Carle.

Unfortunately, this report by the League of Women Voters seems to confirm our worst fears. Without stronger laws that prohibit discrimination, these trends will most likely continue, and a decreasing number of doctors will be forced to serve those Medicaid patients that their peers refuse to see.

As the League continues to fight against this discrimination, we will keep you updated on their success. If either you or someone you know are on Medicaid and have been denied health care at a hospital, please contact the CCHCC's Low-Income Task Force at 352-6533.



CCHCC Board Member Judy Checker (left) and staff member Jim Duffett discuss fundraising activities at the annual Board/Staff Retreat. This year's retreat focused on the development of a long range fundraising strategy.

One million elderly poor miss out on benefits

Last fall members of CCHCC's Senior Citizen Task Force played a key role in conducting a massive national study to find out why half of the elderly poor don't get the help promised to them by federal law.

The Champaign County Health Care Consumers were one of 18 groups in 15 states which interviewed more than 6,000 older Americans at meal and other sites around the country. CCHCC volunteers collected 300 surveys in less than four weeks.

The study, coordinated by the Villers Foundation and released last April, found widespread failure of the federal bureaucracy to inform the elderly poor about their rights under the Supplemental Security Income (SSI) law. Congress created SSI 17 years ago to provide an income safety net for America's poor elderly, disabled, and blind. Under current federal law, every eligible disabled or older American living alone is guaranteed $128 per week.

Despite the law, more than a million poor older Americans are not getting the benefits they need and deserve.

"It's not much to live on, but the tragedy is that half of the poverty-stricken widows who need help aren't even getting this meager bit of support," said volunteer Joyce Reed of Danville. "Our study shows that the government just isn't doing its job of reaching out and helping the people who need help."

Among the study's more dramatic findings:

- The limited knowledge of basic facts about SSI indicates that a lack of information and understanding, far more than embarrassment about applying for help, continues to be the major obstacle to increased program participation;
- More than 90 percent of respondents assumed, incorrectly, that having even a low paying job would automatically prevent an individual from receiving SSI;
- Only 33 percent knew SSI could increase an eligible person's income;
- More than a third thought, incorrectly, that anyone receiving regular Social Security benefits would be barred from also collecting SSI;
- Outreach and public information efforts regarding SSI are at best limited, sporadic, and untargeted. More than 60 percent of those questioned reported never having heard a presentation explaining the SSI program.

In addition to the widespread lack of information, as well as misinformation, regarding SSI, even potentially eligible people who are aware of SSI often do not receive benefits because the complexity of the application process constitutes an often insuperable barrier to program participation.

As one agency official concurred, "Clients don't understand the application process; they cannot understand questions on the application; and, consequently, their answers to questions are wrong. The process just needs to be simplified."

Eula Hamilton of the Urban League of Champaign County explained the dilemma. "If forms are going to be so complicated and long as the SSI form is, the Social Security office is going to need to provide more assistance in filling out the application form."

The Villers study concludes by outlining steps which, if taken, would increase participation in the SSI program. First, a broader, more intense, and systematic public information and awareness effort must be undertaken by the Social Security Administration in order to make SSI a household phrase.

Second, greater investment must be made through Social Security offices and community organizations to undertake a sustained outreach effort aimed at hard-to-reach elders. The federal government needs to provide expanded resources, training and improved capacity to identify and inform homebound and other isolated persons about SSI benefits and eligibility requirements.

Finally, support for individuals in the SSI application process must be institutionalized, including assisting elders in obtaining needed documents, arranging for transportation to the Social Security office to apply, and interpreting and helping to fill out application forms and, whenever possible, simplifying the application and documentation process.

One way such improvements can be made is for Congress to provide funding under the Older Americans Act. This bill, passed in 1987, created a program aimed at increasing participation in SSI. Unfortunately, the bill has remained inoperational since no funds have been appropriated to initiate the program.

However, the House and Senate Labor-HHS Appropriations Subcommittees plan to take up the question of funding this year. CCHCC members and friends should contact their Senators and Congressmen and urge support for funding this program.

CCHCC member Lucille Thompson displays her SSI Aware Certificate. Over 30 CCHCC volunteers received certificates for interviewing 300-plus seniors about SSI.

Board Elections

CCHCC is pleased to announce the election of Judy Checker, Kathleen Jones, and Esther Patt as our newest At-Large Board Members. We also are pleased to report that Mabel Coombs has been elected by the members of the Senior Citizen Task Force to serve as one of their representatives to CCHCC's Board of Directors.

The elections of these new board members were announced at our recent Awards Dinner, and we look forward to working with each of them.

Many senior citizens in attendance were asking legislators to support the Medicare Overcharge Measures (HB 402/SB294) which would prohibit physicians from overcharging senior citizens. Illinois doctors collected over $138 million in overcharges from senior citizens in 1987.

Over 1,000 Lobby for Affordable Health Care

On May 23 CCHCC members joined with over 1,000 other Illinois consumers at the State Capitol to voice their opposition to skyrocketing health care costs, as well as rising utility and insurance rates. Consumers from Danville to Quincy, from Chicago to Herrin, and from dozens of other communities joined together for an update on current legislation and to meet with their elected State Representatives. Members from the Champaign County Health Care Consumers Senior and Low-Income Task Forces traveled to Springfield to meet with our legislators about several important health care proposals.

One of the top issues of the day was stopping doctor overcharges, specifically by supporting the Medicare Overcharge Measures (MOM) drafted by the Illinois State Council of Senior Citizens. According to the State Council, the State's largest senior citizen organization, Illinois physicians overcharged seniors and disabled patients $138 million in 1987. Sixty-four percent of Illinois physicians who treat Medicare patients regularly overcharge senior citizens. Under the MOM proposals, doctors would be prohibited from charging senior citizens more than the 'resonable rate' determined by Medicare.

At the morning briefing session Jerry Prete, President of the State Council, stressed to the group, "The federal government and the insurance industry won't pay more than the Medicare determined reasonable rates. If it's good enough for them, it ought to be good enough for senior citizens." To avoid confusion as to which legislators supported MOM, pledge sheets on the Mandatory Medicare Assignment bill were given out to group leaders who organized meetings between legislators and constituents from their districts. At these meetings, State Representatives and State Senators were asked to sign and indicate their position on this issue.

Prior to Lobby Day, it was unclear which of our representatives supported Medicare assignment legislation. Usually, it is not until our representatives are face-to-face with their constituents and listening to their views that they make a commitment. Locally, only Representative Helen Satterthwaite (D) signed the pledge. Although Representative Tim Johnson (R) stopped by and said 'Hi', he refused to sign the pledge. Senator Stan Weaver, on the other hand, tried to avoid us all day. He nearly succeeded until CCHCC member Katy Flessner grabbed him as he was trying to sneak back onto the Senate floor after refusing to come out and meet with his constituents. When asked his position on MOM, Senator Weaver seemed confused and claimed he didn't know enough about the proposal to say how he would vote. Unfortunately, the Senator seems to have turned to the State Medical Society in his effort to learn more. The following week, he voted against MOM. At least there's no longer any confusion about where Senator Weaver stands.

Although the prospects for passing MOM this year do not look good, the proposal did pass out of committee in both the House and the Senate. Further, the roll call vote in the Senate will be helpful in next year's elections. Though many of our State Representatives were once uncommitted in their support for MOM, Lobby Day did force dozens of our representatives to take a stand. Throughout the day stories were told of how people either changed their legislator's vote or made them get off the fence.

As people were boarding their buses to head home, one senior leader told her fellow activists, "We'll be back next year, but in the meantime, we've got to continue to build public pressure and go back to our districts to educate voters on how our representatives voted."

Representative Helen Satterthwaite (left) meets with CCHCC members in Capitol rotunda. Bill McGrath (center) and Mamie Smith emphasized the importance of passing the Medicare Overcharge Measures.

Consumer Awards Highlight Dinner

Our way of thinking in this country is backward, Attorney General Neil Hartigan told CCHCC members. We talk about a person's ability to pay for health care, not about the opportunities we lose when people are in poor health. We are depriving ourselves of the contributions they have to make.

Hartigan made his remarks during his acceptance of the Leadership in State Government Award at CCHCC's Twelfth Annual Awards Dinner and Conference. Hartigan was being honored for his work in establishing the CHIP program, an innovative approach to provide the disabled with health insurance.

The CHIP program gives disabled people the chance to obtain health care which they previously did not have. In turn, these people can make the kind of contributions to our society Attorney General Hartigan envisioned.

Also honored at the Awards Dinner were State Representative Barbara Flynn-Currie, the Illinois Alliance of Midwives, the Women's Health Practice, and outgoing CCHCC Chairperson Susan McGrath.

Rep. Currie was awarded CCHCC's Legislative Leadership Award for her committment to and sponsorship of measures aimed at expanding Medicaid coverage. The successful passage of these measures will do much to curb Illinois' high infant mortality rate.

The Illinois Alliance of Midwives received CCHCC's Provider of the Year Award in recognition of its statewide efforts to provide low cost and no cost services to people who otherwise could not access affordable prenatal and women's health services.

The Women's Health Practice received CCHCC's Harry J. Baker Community Service Award honoring its provision of low cost, non-discriminatory health services, as well as providing birth options to local residents.

Susan McGrath was honored with CCHCC's Henrietta De Boer Volunteer of the Year Award. Susan has been a Board member since 1982, serving as Chair since 1985. Her tireless efforts on behalf of the organization have served as an inspiration to board, staff, and membership alike.

In his acceptance speech, Hartigan echoed a common problem which CCHCC has attempted to face during the whole of its existance. The elitist in this country think that we can solve 100% of our problems by applying 30% of our talent, Hartigan said. Blacks are not full participants in our system. Women aren't full participants. Seniors, the disabled, Hispanics -- none are full participants in our system. And no one can be a full participant without good health. By limiting these people's opportunity to participate, we are cheating ourselves, as well as them.

Hartigan implored the audience to continue the fight to grant everyone full participation in our system. "Your organization is an extraordinary one," he said, "truly a grassroots one that has created empowerment. We are trying to ... even up the odds for individuals against pretty large enemies."

Hartigan concluded that we can win this fight. Governor Thompson found out just how effective we can be when last year 210 groups came together to fight for CHIP and won, despite the opposition of the Governor.

Nader

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improvements can be readily made. Nader cited the over prescription of pharmaceutical drugs, the rampant use of unnecessary x-rays and unnecessary surgical procedures as specific instances where quality of care could be improved and costs saved.

In addition, we have models upon which we can base improvements in our system. Certain geographic areas of the country have outstanding local health care systems, such as that in the Puget Sound region. Likewise, specific localities excel in the delivery of one aspect of health care, such as emergency service.

In short, we have the knowledge and the examples to use to vastly improve our health care system right now, but these steps aren't being taken. The culprit, according to Nader, is that power is in the wrong hands.

For example, Nader focused on the issue of malpractice. Several studies have shown that a small fraction of physicians are responsible for almost all of the malpractice claims filed in America. A Massachusetts study found that 13% of physicians were responsible for 99% of claims.

The policing of these physicians is atrocious. The reason is that the power for policing physicians rests mainly in the hands of the physicians themselves. The results can be as ludicrous as the case of a Texas neurosurgeon who was removed from the staffs of twelve small hospitals and

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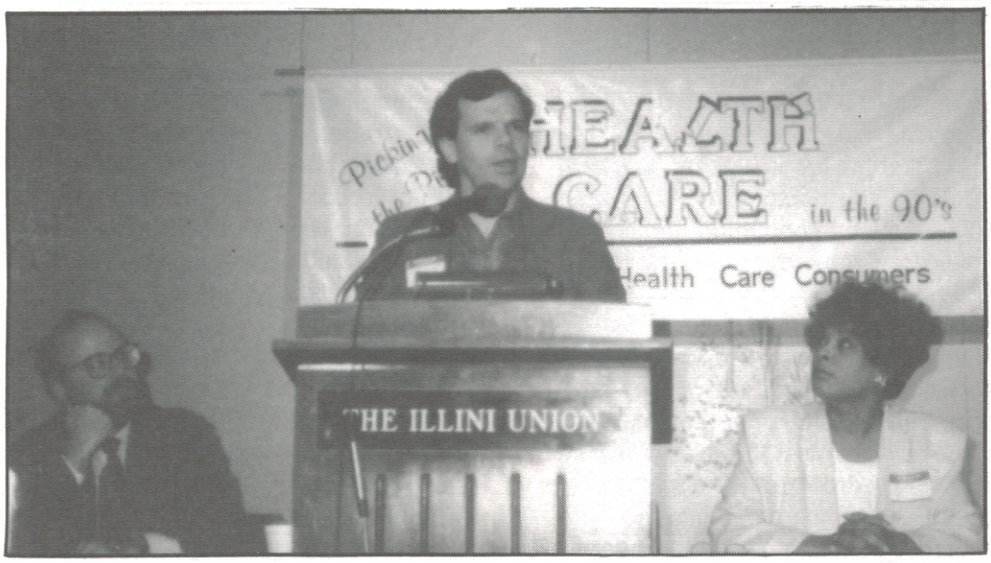

Representative John Cullerton outlines his proposals to require all employers in Illinois to provide health insurance for their workers at CCHCC's Annual Conference. The theme of this year's conference was "Picking Up the Pieces: Health Care in the 90s."

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two major facilities, but never had formal charges levied against him.

Despite the dreary outlook of today's health care system, Nader provided hope for the future. He outlined a three step approach to combating the current system.

First, we must cultivate a national sense of humility. We must overcome the national mentality that our health care system is the best possible. Despite all the abounding rhetoric to the contrary, our system most certainly is not the best possible, or even the best in existence today.

America lags behind many nations in the standard measures of health systems. The infant mortality rate in the U.S. ranks an abysmal 18th. In some pockets of the U.S. the rate is even lower. The infant mortality rate of Washington, D.C. is worse than that of Jamaica.

There are much better health care systems readily observable. Canada spends 9.5% of its Gross National Product on health care. For that money, everyone is covered for all their medical, dental, and long term care. We spend 11.6% of our GNP on health care. Our expenditures leave 37 million Americans uninsured, 30 million more Americans underinsured, most Americans without dental coverage, and a system which provides much lower quality care for the poorest segments of society whose health care is subsidized by the Government.

Second, Nader continued, we must shift our educational focus regarding health care. We must emphasize the development of life skills. We need to learn how to become good consumers; not only to learn that we have choices, but that we as consumers have rights. We must learn to be comfortable operating within a system that has historically excluded the consumer. Our schools should emphasize the need to be active as citizens and to particpate in the decisions that affect us.

Finally, we must translate steps one and two into action. We must bridge the gap between analyzing and documenting a problem and solving that problem. Returning to his overriding theme, Nader re-emphasized that this step involves shifting the power relationships prevalent within our current health care system.

This third step is the charge of the health care consumers and other consumer groups. We have to generate more grass roots power in an informed, organized, and persistent way. Our job as leaders of a consumer movement is to create more leaders from the ranks of those traditionally considered "the have nots."

At this very moment, tens of thousands of lobbyists, advertising executives, and marketing specialists are pushing for physicians to overprescribe useless drugs. We need to encourage the birth of tens of thousands of consumer advocates to counterbalance this pressure, wrest power away from the health industry, and put it into the hands of the people whose lives are dependent upon these issues.

HMOs from page 1

physicians or specialists within the HMO, and reduced responsiveness to the patients's needs, including inordinately long periods before appointments can be scheduled and one to two hour wait times in the office. Difficulties in securing referrals to appropriate specialists outside the HMO have also been experienced, as has a high turnover rate of doctors within HMOs. For these and other reasons, the rosy picture painted for HMOs must be examined more carefully and greater accountability required.

Although organizations resembling HMOs existed as early as the latter part of the 19th century, the great growth for HMOs began in 1973 with the passage of the Health Maintenance Organization Act, which:

-Provided grants, loans, and loan guarantees to HMOs;

-Preempted state laws and practices impeding the development and operation of qualified HMOs;

-Required an employer to include the option of membership in a qualified HMO in any employee health benefit package (dual choice) if the employer: 1) is covered by the minimum wage provision of the Fair Labor Standards Act, 2) has at least 25 employees residing within an HMO's service area, 3) has an employee health benefit plan to which the employer contributes, and 4) has received a written request from a qualified HMO for inclusion in the employer's health benefits program.

On the basis of the HMO Act of 1973, many new comprehensive prepaid health care programs were formed. The June 1981 enrollment in HMOs (subscribers and covered dependents) totaled 10.3 million, nearly twice the enrollment seven years earlier. In 1985, nearly 30 million people were covered by HMOs or PPOs (Preferred Provider Organizations, in which the consumer can choose among doctors who have contracted with the PPO). By 1988, HMOs had grown considerably. For example, in Minneapolis ten HMOs control 41 percent of the health care market. HMOs and PPOs account for 60 percent of private physicians' practices.

Locally, HMOs are demonstrating some of the same tendencies that are appearing nationwide. Membership in CarleCare has increased from 31,454 in 1984 to 97,861 in 1988. For PersonalCare, growth from 1984 to 1988 has been from 9,648 to 41,153. Both CarleCare and PersonalCare will soon initiate a requirement of a $10 copayment for each visit to the doctor's office. In addition, premiums for each plan will increase substantially. For state employees (employee plus two dependents) CarleCare's premium will increase 29% from 1989 to 1990, while PersonalCare's will increase 23%.

At the same time, CCHCC is receiving an increasing number of complaints from local consumers about eligibility, access to primary care physicians, and long waits for appointments. To help facilitate local public debate about HMOs, CCHCC will hold a community forum on HMOs at the Champaign Public Library on Monday, June 26, beginning at 7:00 PM. Titled "HMOs: Medical Reform or Marketing Ploy?", the forum will feature four panelists: Tom O'Rourke, Professor in Health Studies at the University of Illinois; Richard Perry, the President of Patient Account Services; Hank Scheff, Director of Budget & Benefit Analysis for AFSCME Council 31; and Gerry Tresslar, Executive Director of CarleCare HMO.

Congress to Reform Fee Schedule

Patients Fed Up with Doctor Overcharges

Physician costs are out of control and Congress is talking tough. But if Congress squeezes the doctors, will patients be left footing the bill?

Medicare is one of the fastest growing items in the federal budget. For the past twenty years, Medicare costs have increased faster than inflation and faster than health care costs for the rest of the population. If such trends continue, spending for Medicare will outstrip that for Social Security and defense combined in the next twenty-five years.

In 1987, total Medicare expenditures were $79.9 billion -- an increase of 7.7 percent over 1986. Less than two percent of this increase came from hospital costs (Part A). The real culprit was payments for physician services (Part B), which rose 18.9 percent.

Congress and previous administrations have tried several times to curtail this cost escalation, but with little success. In fact, Part B has seen double-digit rate increases since 1973, going up 13.5 percent each year on average -- even during times of Medicare physician fee freezes.

The simple fact is, while fee freezes and other Congressional action may have somewhat curtailed price increases for the individual services a physician might provide, they have done nothing to prevent doctors from merely prescribing more services and tests to increase their Medicare payments. Nearly half of the cost increases over the last decade have been the result of physicians increasing the number of services and tests they bill Medicare. The connection is clear: the more services for which doctors bill, the higher their income.

The upshot is that doctors have been doing very well at keeping ahead of inflation -- and of attempts to cut Medicare. The average net income of physicians after paying expenses rose 31 percent from 1981 to 1986, reaching $132,300 in 1987. (If you exclude doctors who are employees and only look at self-employed physicians, the average shoots up to $146,200.)

In response, Congress created the Physician Payment Review Commission (PPRC) three years ago for the purpose of developing options for reforming the way Medicare pays doctors. This spring, the Commission presented several important recommendations to Congress, including a proposal for a total overhaul of the way Medicare sets its fee schedule for physician payments.

What will these changes mean for beneficiaries? Since the doctors whose fees will rise the most under the new fee schedule are also the doctors people see the most, it's likely that the total amount seniors pay for co-insurance (20 percent of each approved bill) will go up slightly.

A greater concern is what will happen to overcharges -- amounts that doctors charge patients over and above the Medicare payment rate. This practice of overcharging patients is sometimes called 'excess' or 'balance' billing.

Although doctors claim that they take patients' economic status into consideration when deciding if they will charge a few dollars more, the evidence shows that the poor often are overcharged. Data developed by the PPRC show that one-third of the poor who are not on Medicaid are overcharged. Further, the most highly paid specialties are the worst offenders.

There is a danger that doctors who lose out under the new payment schedule, receiving lower reimbursements from Medicare, will try to make up the difference by overcharging patients even more.

What can be done about this? Most senior and consumer groups believe that the best way to prevent doctors from shifting costs onto beneficiaries is to require doctors who get money from Medicare to accept 'assignment.'

Although the PPRC did not recommend adoption of mandatory Medicare assignment, it did recommend several steps to minimize cost-shifting by doctors if the fee schedule is revised.

Unfortunately, most of the recommendations were watered down proposals that failed to go far enough. Therefore, citizens organizations aroung the country, including CCHCC, are pushing for several proposals to limit doctors fees. CCHCC members are encouraged to mail the enclosed postcards to Representative Terry Bruce and Representative Rostenkowski, urging them to support these consumer oriented reforms.

Champaign County
Health Care Consumers
44 Main Street/Suite 208
Champaign, IL 61820

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