BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-THIRD CONGRESS

SECOND SESSION

PART 13—WASHINGTON, D.C.

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BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

TUESDAY, JUNE 25, 1974

U. S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE ELDERLY OF THE
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 308, Russell Building, Hon. Edmund S. Muskie, chairman, presiding.

Present: Senators Muskie, Moss, Mondale, Fong, Percy, Hansen, and Domenici.

Also present: William E. Oriol, staff director; Val Halamandaris, associate counsel; Elizabeth Heidbreder and John Edie, professional staff members; John Guy Miller, minority staff director; Margaret Fayé, minority professional staff member; Gerald Strickler, printing assistant; Yvonne McCoy, assistant chief clerk; and Donna Gluck and Joan Merrigan, clerks.

OPENING STATEMENT BY SENATOR EDMUND S. MUSKIE, CHAIRMAN

Senator MUSKIE. The subcommittee will come to order.

Today, we continue the inquiry of this subcommittee into "Barriers to Health Care for Older Americans," a series of hearings to assess the health care needs of our older citizens.

These hearings have been held in and outside Washington, but no matter where they have been, the rising costs of medical care to the elderly have emerged as a dominant issue.

In our last hearing, statistics showed how Medicare premiums, deductibles, and coinsurance charges have risen since the beginning of the program. The deductible, for example, under the part A hospital program has more than doubled. Hospital Medicare patients paid $40 of first day hospital charges in 1966 compared to $84 today.

We also heard that many health services, such as preventive care and outpatient drugs, are not covered at all by the program. Medicare—despite its valuable protection—now covers only 40 percent of the average annual medical bills for aged persons.

The witnesses we will hear this morning will show in very human terms what the statistics mean. They will describe what the lack of comprehensive coverage can mean for those who feel that they cannot afford health care and consequently neglect to seek the care they need.

And when older people do seek care, they may be in for a shock. This is illustrated by the two exhibits[1] we have which demonstrate

[1] See next page.

how one woman was dunned for a bill which she thought was covered by Medicare. "Sorry—Medicare refused to help" she is informed and she is also reminded that "Honesty is the best policy."

SORRY -- MEDICARE REFUSED TO HELP

IT'S BEEN A LONG TIME...

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HONESTY IS THE BEST POLICY

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This billing of the aged for medical services believed to be covered by Medicare is by no means uncommon and can be devastating to the many elderly living on very limited incomes. One elderly woman testifying before this subcommittee told how she budgeted her annual income of $2,295.80 for rent of $1,104 per year and other absolute necessities and had only $20.54 for such "extra" expenses as clothes and doctors' fees.

Consumer confusion concerning just what Medicare will pay is rampant. A study soon to be published by the Committee on Aging points out the "shock of disappointment and the confusion resulting when anticipated Medicare claims are not paid and the elderly individual is required to make payments himself." [2]

This is one of the issues that will be addressed by our witnesses today. They will describe the large and unmet health needs discovered when a clinic operated by Abbott Northwestern Hospital and Minneapolis Age and Opportunity Center accepted Medicare as full and final payment for services rendered.

In addition, the role of the intermediary Blue Cross company in approving or disapproving Medicare claims will be explored. Methods used by intermediaries in processing claims are the result of a bewildering complexity of regulations and judgments which need to be examined with regard to the effect on the medicare beneficiary.

At the same time, we will be hearing about the dual roles of Blue Cross as a marketeer of medi-gap health insurance policies to the aged.

These are all important issues, and I look forward to the testimony of our witnesses.

I welcome my colleagues and invite them to make such comments as they desire.

Senator Moss?

STATEMENT BY SENATOR FRANK E. MOSS

Senator Moss. Thank you, Mr. Chairman. I am pleased to be here this morning as the Senate Committee on Aging continues its efforts to identify "Barriers to Health Care for Older Americans."

In the early years of my membership on this committee, there was no question but that health care was the overriding concern of senior citizens. We found seniors were sick three times as often and hospitalized three times as long as the younger population. Their health costs were more than three times as great as their younger counterparts while they had less than half of the financial resources to deal with them.

For these reasons, the Congress, in 1965, enacted the Medicare program establishing basic health care as a right for all Americans. More specifically, the Congress mandated that there should be no relationship between ability to pay and the availability of quality health care.

Today, 9 years later, Medicare has become a broken promise. Quality health care is still far from a right for older Americans; it is still intrinsically tied to ability to pay.

The elderly are caught in a vicious three-way squeeze. First, they must pay more to participate in Medicare; second, Medicare pays less and less of the average senior's health expenses; third, because of

[2] *Private Health Insurance Supplementary to Medicare,* a working paper, U.S. Senate Special Committee on Aging, Dec. 1974, 31 pp.

today's galloping inflation, they must proportionately spend more of their income on food and housing, and have less money left over with which to pay the growing proportion of their medical expenses that Medicare will not cover.

A few statistics will illustrate these trends. In 1965, the Congress decided that Medicare should have two parts: Part A, or hospital insurance, which was mandatory; and part B, medical insurance, which was optional and required seniors to pay a monthly premium of $3 to enroll in the program.

Today, the premium that seniors must pay if they expect Medicare to pay physicians' charges has increased 123 percent to $6.70 a month. Moreover, the senior was required to pay the first $40 of his hospital bill in 1966, and he now must pay $84 or an increase of 110 percent. At the same time Medicare, which paid 46 percent of the average senior's health expenses in 1969, has paid less and less in each succeeding year, now paying for only about 40 percent of the bill.

Today, seniors pay an average of $303 a year out of their own pockets which is $69 more than the total health bill paid by seniors the year before Medicare was enacted.

Many critical health needs are not covered at all. Medicare does not cover out-of-hospital drugs, dental work, eyeglasses, hearing aids, or nursing home and home health care to any substantial degree. Tragically, it does not cover preventive medical care such as immunization.

All of these facts and the mail I received leads me to the conclusion that health is still the primary concern of older Americans. It is my great fear that thousands may be going without the care that they need because they cannot afford it and they know Medicare won't pay for it.

I believe these hearings are important to help us measure the health problems of seniors and to highlight their needs against the background of pending national health insurance plans.

I am pleased to welcome Mrs. Daphne Krause, from the Minneapolis Age and Opportunity Center, who has, in the past, appeared before the Subcommittee on Long-Term Care. I am sure that she and those who accompany her will make an excellent presentation.

Senator MUSKIE. Thank you very much, Senator Moss.

Senator Hansen, do you have a statement?

Senator HANSEN. No; I do not.

Senator MUSKIE. Senator Domenici?

STATEMENT BY SENATOR PETE V. DOMENICI

Senator DOMENICI. I do have a brief one. I want to thank our chairman for permitting me to conduct a hearing in the State of New Mexico on "Barriers to Health Care for Older Americans." I did that some 2 weeks ago.

I think it is highly appropriate while the Nation is looking at national insurance health programs that this kind of hearing takes place so that we can inform the American people who might assume that the health care of our senior citizens has already been taken care of and that we ought to be on with other things.

I think it is important that we let them know that we have not even begun to meet the needs of our senior citizens, much less the rest of our population.

In fact, as I conducted hearings in my State and from the correspondence I get, I assume there are almost as many unmet needs as there are met needs.

Some of the most chronic and natural ailments of our senior citizens are not even now covered under Medicare at all. Eyes, ear care, out-of-hospital drugs, these kinds of things are plaguing our senior citizens and we do not want Americans to think, as we look toward health care for all our senior citizens, that we do not have to make a real emphasis on any approach toward our senior citizens' unmet needs. Our programs tie into this.

Now, the information system that our country now has with reference to eligibility and responsibility into Supplemental Security Income community projects, our senior citizens are having great difficulty to even find out what they are entitled to.

Transportation to and from the services we provide is a major problem; boardinghouses and nursing homes, which are an intricate part of care, are in such a state of confusion and lacking in regulations that some are truly a disgrace to our country and to the States which have such facilities within them.

I am pleased that we are going to focus in on the shortcomings of Medicare as we approach a full-scale hearing for our people in this country on unmet health needs for all our people.

I thank the chairman for permitting me to participate in our State in the past and compliment him for the hearings we are having today and for the rest of this week.

Senator MUSKIE. Thank you, Senator Domenici.

Senator Hubert H. Humphrey, of Minnesota, has submitted a statement for the record. Without objection, it will be inserted into the record at this point.

PREPARED STATEMENT OF SENATOR HUBERT H. HUMPHREY

Mr. Chairman, I want to commend you for holding this hearing on "Barriers to Health Care for Older Americans," which is one of the most important issues facing Congress today. I also want to welcome all of the distinguished citizens from Minnesota to this hearing. I regret that circumstances prevented my being present to listen to your presentations. Let me assure you that I will read the transcript of this hearing with great interest and care.

The urgent need for reform in health care delivery systems and financing is evident to all of us. The overriding problem that you are addressing today is simply that all too many elderly persons in America cannot, on their own, afford the cost of adequate health care. We must not continue to allow spiraling health care costs and gaps in insurance coverage to place our elderly population outside the mainstream of our health care system. We must protect these Americans from the financial ruin all too often associated with a major illness that occurs so commonly with age.

Older Americans need more health care but at the same time they have less money. Real growth in health care utilization for the elderly has not kept pace with other age groups in recent years. Therefore, the elderly are not utilizing the full range of health services they need. They are economically forced to wait until they need acute inpatient hospital care. The elderly in America are further discouraged from obtaining health care because they are concentrated

in central city and rural areas that are geographically isolated from health service areas.

In recent years, Congress has been attempting to deal with the most urgent needs of our elderly population. The Medicare program has enabled our older citizens to obtain some basic health care, but there are still many problems. The average Medicare patient now pays more in out-of-pocket expenditures for health care than he did before the inception of the program.

The average personal health care for the aged in 1973 was $1,000, but the average out-of-pocket payment was $276. In 1969, Medicare paid 46 percent of their health bill, but today it pays only 42 percent. This decline in Medicare's share of the health bill of the aging is a primary problem of the total health care picture in America today. We must do something about it. I hope this hearing and the experience of the Minneapolis Age and Opportunity Center clinic for the elderly will help generate some solutions to this problem which seems to be increasing daily.

I am proud of the successes that Minnesota has shown in providing health care for the aged. The senior citizens' clinic is an important example for the entire American health care community. I hope the Minneapolis Age and Opportunity Center and the personnel at the Abbott-Northwestern Hospital keep Congress informed of their successes and their problems. This hearing is an opportunity to generate some excellent solutions to the health problems of the aged by discussing the impressive progress of the Abbott-Northwestern/M.A.O. senior citizens' clinic.

I again want to thank all of my friends from Minnesota for sharing their experiences with Senator Muskie and the members of the Subcommittee on the Health of the Elderly.

Senator MUSKIE. We have some very interesting witnesses today. I would like to say to them that it is not necessary that you read all of your statement. Whatever is not read will be included in the record as though it were read.

What we want, of course, is a dramatic and effective presentation.

I am delighted to have Daphne H. Krause, executive director, Minneapolis Age and Opportunity Center, Minneapolis, Minn.; George Adamovich, administrator, Abbott Division, Abbott-Northwestern Hospital, Minneapolis, Minn.; Thomas Werges, M.D., diplomate, American Board of Internal Medicine, Community Medical Associates physician; Roger Farber, M.D., board certified neurologist, member, board of directors, Community Medical Associates; Lavetta Pearson, R.N., director, Abbott-Northwestern Hospital/Minneapolis Age and Opportunity Senior Citizens Clinic; Judith Lampert, R.N., assistant to the executive director of the Minneapolis Age and Opportunity Center; Carlos P. Sullivan, Jr., M.D., neurology resident, University of Minnesota Board Eligible for Neurology.

Mrs. Krause, we leave it to you to handle your group and to make your presentations.

STATEMENT OF DAPHNE H. KRAUSE, EXECUTIVE DIRECTOR, MINNEAPOLIS AGE AND OPPORTUNITY CENTER, INC., MINNEAPOLIS, MINN.

Mrs. KRAUSE. Mr. Chairman, on behalf of myself and all of those involved with the Minneapolis Age and Opportunity Center, Inc. (M.A.O.), I want to thank you for allowing us to appear this morning to tell our story. It is more than the story of M.A.O., it is a graphic lesson answering the question of what kind of services are needed by today's senior citizens.

If a senior citizen is active and alert, with reasonably good health and had sufficient income to provide for living expenses and medical

care, it is unlikely they would need the kind of services M.A.O. provides. But, I can conservatively estimate based on our experience that one out of every five, or 20 percent of our seniors, need some sort of help, ranging from at one end of the spectrum, friendly visiting or telephone reassurance to acute care, requiring immediate admission to the hospital, or institutionalization. It is my conclusion that by providing a broad spectrum of services, such as we have at M.A.O., you can maintain most seniors in independence avoiding or postponing institutionalization at considerable savings to the taxpayer, or if services are not provided in time, the elderly will rapidly deteriorate requiring expensive hospital or nursing home care.

In order to find out the combination of services that were needed, in 1968, I met with around 40 senior citizens every day for a 6-month period, during which time we discussed the kinds of problems that existed. We then wrote the original concept of M.A.O. based on their foremost concern, which was to develop alternatives to nursing home care.

M.A.O. Incorporated

Finally, we incorporated M.A.O. as a nonprofit agency, May 18, 1969, and started to seek funding for the services and a policy was developed on how we were to finance M.A.O.

It became obvious that if we had determined that 20 percent of the 194,000 senior citizens in Hennepin County might need our services, on either an episodic or ongoing basis, it was unlikely that we could be funded by Federal grants at a high enough level to serve this amount of people. And in any event, the seniors felt strongly, as I did, that we should only be using Federal money for programs that could not be produced by the community.

It was on this premise, then and later, that we established a consortium of community partners in order to reach our goals.

The first year, 1968, I was officially employed without salary, by the M.A.O. board and we operated without funds in space donated by Abbott-Northwestern Hospital, Inc., with volunteers assisting me.

The second year, 1969, M.A.O. had a grant from title III AoA for $32,592 which funded three staff with space, phones, and so forth, still being donated by Abbott-Northwestern Hospital. This expired in June 1970. M.A.O. also received funding by OEO for $20,000 for 6 months which enabled M.A.O. to meet some needs in Hennepin County. However, the CAP agency was removed from this city.

Since June 22, 1970, M.A.O. has received its principal funding from Model Cities. The senior citizens program received top priority out of 70 projects.

M.A.O. is now in its fourth year of funding with Model Cities, receiving $240,764 for 1974. This grant expires December 31, 1974, unless Model Cities receives further funding.

The Model Cities grant provides us with 22 employees.

In addition to the Model Cities funds, as of January 1, 1974, M.A.O. was awarded a grant by title III through the Governor's Council on Aging for $110,694 which combined with our expansion of subsidized health services through Abbott-Northwestern Hospital has, for the

first time, enabled us to expand our medi-supportive program to Hennepin County.

This grant also expires December 31, 1974, and even if it is renewed, it will be cut 15 percent and as the majority of this funding is for field staff providing direct services, it will mean a serious cut in those services. Thirteen employees are provided by these funds.

From the community consortium, we have four staff funded by Abbott-Northwestern Hospital, Inc., one staff funded by the Junior League of Minneapolis, and one funded by the Hennepin County Bar Foundation, for a total of 41 staff in the agency.

There are approximately 107 volunteers working with our agency.

Finally, we receive around $1,500 a year from the St. Mary's Friends Organization for crisis funds. This supplies funds for emergency food and lodging, clothing, and so forth, and for what I call intangibles.

I would like to describe such an intangible. Many seniors, as they become isolated and the community turns away from them, look to pets for love and companionship. In this case, the lady started with 2 cats which rapidly developed into 24. The housing authorities were very upset by this and demanded either the cats or the lady be removed from the premises.

First, we had to persuade the lady to give up her cats and we would provide her with a pet that was not as obnoxious. She agreed to do so, if we would find all the cats homes, which we did at no small effort. Then we took her to a shop to purchase two lovebirds, a cage, food, et cetera. Now, I wouldn't like to have to explain to our Federal funding sources that I had purchased birds and cages, et cetera, yet the fact is that without something to love and care for, this woman's loneliness would probably have led to a deterioration of her health.

At this point, Mr. Chairman, I would like to introduce for the record, a statement from Mrs. Lynn McCarthy, chairman of our project with the Minneapolis Junior League, which I think expresses very well what I have tried to describe, the consortium of M.A.O. and its partners. It also shows in more depth the league's tremendous contributions to M.A.O. and the senior citizens of Minneapolis.[1]

As you can see, we have had outstanding contributions from the community, and in particular from Abbott-Northwestern Hospital, Inc. This I have not attempted to discuss in detail now, because it is so closely intermeshed with M.A.O. and anything we may have achieved, that it will unfold through our entire presentation.

Federal Funds Difficult To Obtain

However, our Federal funds are another matter altogether. They are fragmented, they have been extremely difficult to obtain because the guidelines are not designed for comprehensive programs, and their insecurity is of serious concern to us. As you will see, we are dealing with people's lives, and this insecurity leads to a grave concern on the part of all of us, as to what will happen to these senior citizens if our funding does not continue. Who will be responsible for these people?

[1] See appendix, item 1, p. 1311.

It should be noted that M.A.O. has never received any funds for planning or grantsmanship. This responsibility I assumed on volunteer time and continue to do so.

Mr. Chairman, I would like to acknowledge the support of Minnesota's Senators and Congressmen on both the National and State levels. In particular, Senator Mondale, Senator Humphrey, Congressman Don Fraser, Governor Wendell Anderson, and our mayor, Al Hofstede, whose support has enabled us to continue to serve our senior citizens.

I would also like to acknowledge the leadership and support of our senior citizens in Minnesota.

The board of M.A.O. is a policy board, composed of senior citizen leadership from State and citywide organizations, chosen by senior citizens. Any senior citizen group may apply for representation on the board. I am employed by and directly responsible to this board.

In order to describe our services, I coined a term "medi-supportive" services. It is meant to show the close relationship that we believe should exist between health and supportive services, that is necessary for a comprehensive approach.

We believe that health can no longer be the traditional doctor, hospital, and nurse and end there. It must include those services needed prior, during and after medical intervention in order to provide a continuum of care.

Mr. Chairman, because there will not be time to fully discuss our services, I would like to introduce into the record a book I wrote describing in more detail our services, even though I have some hesitation in doing so, because since I wrote it in 1973, there have been many more developments to the M.A.O. program, and I have not had time to write another.[1]

M.A.O. Services in Brief

I am also introducing a shorter descriptive version of our services for your convenience.[2]

These services are:

1. *Home delivered meals.*—We deliver meals-on-wheels 7 days a week, two meals a day, to provide essential nutrition for the seniors. Seniors who are able to pay, may do so and contribute toward the cost of the meals. In emergency situations, we have other staff and volunteers who will fix meals for the seniors in their own homes. The driver is trained to observe and report on the clients' health.

2. *Homemaker services.*—To maintain many seniors in independence, we have found home care essential. This includes help with grooming, bathing, housework, laundry, et cetera. In addition, we offer home handyman services to help in fixing and mending the residence, furniture, or appliances.

3. We help many seniors in the Twin Cities area to find part-time employment to supplement their incomes.

4. We provide transportation services to take people to medical appointments, and shopping for groceries if unable to use public trans-

[1] Retained in committee files.
[2] See appendix, item 2, p. 1312.

portation, through the use of our staff and volunteers. We also provide emergency transportation on a 24-hour basis. We have six vehicles and one truck. All are equipped with a radio.

5. We provide legal services for seniors—it is surprising how many are in great need of an attorney's help, but are unable to afford such help, without which they can be in serious trouble.

I am reminded of the senior citizen who was committed to a mental institution simply because he didn't follow his doctor's orders. If we were to follow that notion, you would have to commit at least half of our population, including myself. Our attorney got this and other such committals reversed.

6. We provide telephone reassurance to a senior with medical problems once a day. This mitigates their concerns of becoming ill and no one finding them for days while they lie there helpless, as happens to many senior citizens.

7. Dial-a-friend brings seniors together with common interests and hobbies.

8. We provide assistance in obtaining health services, filling out medicare and other insurance forms, and provide emotional, drug, and alcoholic counseling.

9. We provide information on any resources that exist, such as subsidized housing, et cetera, and directly aid the seniors to get on these programs if they are eligible.

10. We have many programs in the volunteer section, with volunteers providing services in all areas. We have a program with channel 11, Metro Media, to bring together young and old in a mutually rewarding relationship.

We provide for better nutrition and encouragement to the seniors to get out into the community through our program, meals in the community, with the Minnesota Restaurant Association. Over 156 restaurants have joined to give seniors lower cost meals in their off-peak hours.

11. In conjunction with Abbott-Northwestern Hospital, Inc., we provide a senior citizens clinic. I want to talk about this clinic in some detail later in my statement.

12. Finally, we provide counseling services which are the catalyst that makes the entire program work. Our counselors go out into the community or see seniors who come into our offices and determine what their needs are. I want to emphasize that we first survey the resources available to the client in the community, and provide services ourselves if there is no one else to do it. Our counselors help clients with personal problems and to obtain assistance from programs like Medicaid, SSI, services to the blind, or food stamps. We tailor the services we provide to each client's needs, not to the agency's convenience.

We provide these services:

1. In our center and clinic;

2. In the home;

3. And in the community at mini-centers. The space for these mini-centers is donated to M.A.O.

Our services are given on three general levels:

1. First we call preventive;
2. A second rehabilitative;
3. And third supportive.

Mr. Chairman, I would like to note at this time, that through Abbott-Northwestern Hospital, Inc., we are presently funding and supporting administratively the only black senior citizens group in Minneapolis, and as far as I know in Minnesota, called U Meet Us Senior Citizens, Inc., for which I wrote a proposal that I am introducing into the record. I believe its contents provide insight into the problems of minority senior citizens. We are attempting to get this proposal funded.[1]

We are currently serving around 8,000 senior citizens through our medi-supportive services and over 20,000 in our voluntary programs and services.

Mr. Chairman, I would like to enter into the record at this time, statistics showing the number of services delivered by M.A.O. from July 1, 1970 to May 31, 1974. There were a total of 431,686 services given, as follows:

Total Services Given by M.A.O. From July 1, 1970–May 31, 1974

Service:	*Number*
Home delivered meals	162,008
Employment	5,081
Homemaking and chore	9,716
Transportation	24,985
Legal	88,383
Counseling	37,047
Information and referral	36,537
Volunteer	40,640
Health (from Jan. 1, 1972 to May 31, 1973, health services were not required to be required before this date)	27,289
Total services	431,686

Note. Staff provided many volunteer hours.

Earlier, I referred to our clinic with Abbott-Northwestern Hospital, Inc. This was founded early in 1969, after I had talked to Mr. Robert Millar, who was then president of Abbott Hospital, about the concerns seniors had in finding adequate medical care. Some of the reasons were because of the loss of their own physician, through their moving out to their neighborhoods into highrises or their physicians retiring, and because many physicians are reluctant to take on older patients because of their multiple health problems, and their feeling that this is not a rewarding practice, due to the poor prognosis for many of these seniors.

It was agreed with Mr. Millar that this clinic would be open to all people of all incomes, and that costs would be kept at a moderate level, with reimbursement by Medicare, other third party insurance, and the patient.

[1] Retained in committee files.

It should be noted that while it was not publicized during the first years of the clinic, should M.A.O. perceive that a patient could not afford to pay the remainder of their bill, Abbott-Northwestern Hospital, Inc., on our recommendation, absorbed those charges. By 1973, we were serving approximately 700 patients in our clinic.

Mr. Chairman, I would like to enter in the record the memo I received from Mr. Millar that founded our clinic.[1]

Mr. Chairman, I would like to introduce Mr. George Adamovich, who is with me today to present our story. Mr. Adamovich is the administrator of the Abbott Division of Abbott-Northwestern Hospital, Inc.

STATEMENT OF GEORGE G. ADAMOVICH, ADMINISTRATOR, ABBOTT HOSPITAL DIVISION, ABBOTT-NORTHWESTERN HOSPITAL, INC., MINNEAPOLIS, MINN.

Mr. ADAMOVICH. Mr. Chairman, my name is George Adamovich. I am the administrator of the Abbott Hospital Division of the Abbott-Northwestern Hospital, Inc. I am here today because it is our hospital which has worked closely with the Minneapolis Age and Opportunity Center program of comprehensive services to senior citizens.

It has been our unique privilege to assist in the development of a program which, for the first time, brings together in a fully coordinated system, health and social services to attack the practical problems of maintaining the health and independence of our elderly population. I believe it to be a viable, economically sound alternative to institutionalization for so many of our senior citizens. We are gratified to know that we have had a part in the development of a program which has such enormous impact on the dignity and quality of life for so many people in our community. It has truly set the pace for the Nation.

A VOLUNTARY NONPROFIT HOSPITAL

Mr. Chairman, with your permission, I will take a moment to describe the background and characteristics of Abbott-Northwestern Hospital, the organization which I represent. Abbott-Northwestern Hospital, Inc., is a voluntary nonprofit hospital located in the center city of Minneapolis, Minn., with assets of approximately $37.5 million, and, operating two acute general hospitals approximately 1½ miles apart. Its board of directors, chaired by Dean McNeal, is a broadly representative group of distinguished citizens who volunteer their time managing the affairs of the hospital in the community interest. Robert C. Millar is president of the hospital and its chief executive officer.

Abbott-Northwestern Hospital came into existence in January 1970, through a merger of two prestigious hospitals in the Twin Cities—Abbott Hospital, having 336 beds, located at 110 East 18th Street, and Northwestern Hospital, having 465 beds, located at Chicago and 27th Streets. The merger testifies to the recognition by the board of directors that medium-sized hospitals, located in the downtown area,

[1] Retained in committee files.

cannot go it alone in a time of rising costs, changing consumer expectations, and revolution in health-care delivery systems.

Our board of directors, recognizing the sophistication of its medical staff and hospitals, began to develop a regional medical center. Abbott-Northwestern is a partner in the Minneapolis Medical Center, Inc., which includes the Minneapolis Children's Health Center and Sister Kenny Institute, colocated with our Northwestern Division. Together, we share services, work to eliminate unnecessary and costly duplication and share services and expertise with many hospitals throughout Minnesota, and some in neighboring Wisconsin.

Abbott-Northwestern, in addition to a full range of acute medical-surgical services, has developed exciting new specialized programs, such as an alcoholic treatment and chemical dependency program with both acute and residential facilities, a community mental health center featuring inpatient and outpatient care for all age groups—together with a community-controlled, hospital-funded neighborhood counseling center. There are no Federal funds in this program. The hospital has recognized a growing responsibility for service to the immediate neighborhood and supports community medicine through community clinics.

So we have as our patient population some of the wealthiest people and some of the poorest people in the metropolitan area. The hospital views itself as a member of the local community and has participated as a responsible member of that community. We have been a leading member of organizations in the community which through the years have worked to preserve the community as a good place in which to live and work.

One might look upon our concern with the community as enlightened self-interest; we feel we can remain healthy only in a healthy community. Through the years, Abbott-Northwestern has given support and encouragement to many community organizations. We have had a particular interest in the problems of the elderly through our association with Mrs. Krause and the Minneapolis Age and Opportunity Center, but also because of the elderly's being a significant component of our neighborhood.

Mr. Chairman, I would like to introduce for the record two supporting documents entitled "Neighborhood Organizations Supported by Abbott-Northwestern Hospitals" [1] and "A Summary Profile of the Elderly in Minnesota." [2]

Abbott Hospital-M.A.O. Cooperation

For the record, our relationship with the Minneapolis Age and Opportunity Center preceded the actual incorporation of M.A.O. Bob Millar, then administrator of Abbott Hospital, had worked closely with Daphne Krause in several community service projects, including the development of a Boy Scout troop for center city kids. Mrs. Krause shared her vision with Bob Millar, and he recognized the potential such a program could have to the seniors in our community. To that end, in-kind support began with space, a desk, and a phone. As the

[1] See appendix, item 3, p. 1317.
[2] See appendix, item 4, p. 1317.

program evolved, our admiration and conviction about its rightness grew, and, correspondingly so did our support.

Health care ranked high among early priorities established by the senior board of the newly formed M.A.O. organization. The result was a clinic program in 1969, jointly sponsored by the hospital and the center.

The original senior citizens' clinic was based in the outpatient department of Abbott Hospital. In this setting, the hospital made arrangements for private physicians to be available at specified times to provide care to M.A.O.'s clients. The physicians charged for their services on a regular fee-for-service basis.

STATEMENT OF DAPHNE H. KRAUSE—Continued

Mrs. KRAUSE. As we continued delivering our program, it was inevitable that we became aware there were many senior citizens receiving our supportive services who were not getting the medical care or drug prescriptions they needed, because of the gaps not covered by Medicare, or by the "medi-gap" policies they purchased in a desperate attempt to meet their medical needs. I discussed this situation with the hospital. These two concerns meshed. I also knew that in order to know how many people fell in this medically deprived corridor, that is, between the people who were so poor that they qualified for medical assistance, which covers costs above Medicare, and the other end of the scale, those who have sufficient incomes to pay for the medical care, I needed somehow to subsidize this inbetween corridor of people for their costs above Medicare. At this point, it may be argued that the county hospitals should be caring for these people who fall in the corridor, but contrary to belief, patients are charged graduating fees if they are not eligible for medical assistance.

Mr. Chairman, I am going to enter into the record a large number of statements from the clients and you know the seniors are fearful of their names being exposed so in order to preserve the validity of their statements, each case is given a case number and I would ask you keep these in confidentiality.[1]

Senator MUSKIE. We would be delighted to do that.

INFORMING THE PUBLIC

Mrs. KRAUSE. Once the hospital had agreed to provide this program, starting November 1, 1973, I wrote a newsletter to the senior citizens to inform them of this wonderful opportunity. I wrote it as clearly and concisely as I could, so that these seniors would understand. I have since found out this newsletter was offensive in some quarters, as they felt it was "soliciting," a point which is totally incomprehensible to me. What on earth is the good of developing a program to meet peoples' needs unless you tell them about it, and provide as wide a distribution as possible in the hope that those needing it will hear about it.

Mr. Chairman, at this point, I would like to introduce the newsletter into the record.[1]

[1] Retained in committee files.

Amongst other benefits, the newsletter tells seniors they are eligible for this program if their income is less than $5,500 for a couple or $4,500 for a single person, there is no limitation on their assets, providing the assets do not affect their income.

It goes on to say that all deductibles for the clinic doctors and hospital, inpatient or outpatient, and all costs above Medicare will be absorbed by the hospital. That anyone who has part A and part B of Medicare is eligible. That clinic patients may get the first three pints of blood free if they cannot afford it and don't have anyone to replace it. That prescription drugs may be bought at the hospital pharmacy for hospital costs plus the cost of bottling the drugs which, of course, is at less cost than what they can be purchased for in the community. It was also noted that a number of affiliate specialists had agreed to accept Medicare as full payment. These included a gynecologist, psychiatrist, ophthalmologist, radiologist, and a neurologist. We know that many other specialists would probably join as affiliates if it were not for the deductible they would have to absorb.

Transportation services are also offered on a 24-hour basis if necessary. This service is offered by M.A.O. drivers or other staff.

The Primary Health Care Physicians are fully covered as they are employed through the Community Medical Associates which Dr. Farber will describe later.

A dietitian's services are available free. Also, mental health services through M.A.O. and/or other services. We hope later to add dental services, and a special pharmaceutical educational service.

It was around this time that during a discussion with Mr. Adamovich, he told me that he felt in order to preserve the high standards that Abbott-Northwestern Hospital, Inc., has of providing quality health care, he felt that these new patients should be provided with a full diagnostic and physical examination in order to know where they were at medically.

I pointed out to him that if my premise was accurate, these people's medical problems would be so acute, that they would need this anyway, and that going the route he was suggesting would mean the hospital absorbing a heavy cost unnecessarily, but he still insisted that he felt this should be done, so we agreed that the intake of these patients should be handled in three phases:

1. First phase, they would see an M.A.O. counselor to assess their social and service needs and a nurse to provide a health history
2. In the second phase, they would have a number of diagnostic tests and,
3. In the third phase they would see the physician for their physical.

Newsletter Gets Huge Response

Immediately after the newsletter went out, the community's response was overwhelming. Our telephones began ringing off the hook, we had no money to hire additional staff, and the phones were overloaded. Abbott-Northwestern Hospital provided us with a number of additional phone lines, but that still wasn't enough. The Junior League came in droves to help us, but that still wasn't enough. Our switchboard broke down, and it was immediately repaired. We then

had to put in more phone lines with different numbers, because the clients we were already serving couldn't reach us. In those first 3 months, we registered about 7,000 individuals, and this placed such a load on the clinic that we have been unable to secure enough doctors and nurses to see all the patients who registered, believing they had immediate and unmet medical needs.

Our staff were faced with the horrendous choice of choosing between the sick and trying to decide who needed help the most urgently.

During this first onslaught, we attempted the phases we had agreed to, bringing in the seniors 100 at a time. We extended our working hours from 8:30 in the morning until 9:30 at night, 7 days a week, which by the way, we are still continuing.

Our 24-hour emergency demands became excessive. Up until now, our clinic had been held in the outpatient department of Abbott Hospital. This became so crowded that the regular patients of the hospital could not get in. One of the Community Medical Associates doctors, Dr. Scallon, opened his offices weekends to us and we were busing patients, nurses, and doctors to his office. Mr. Kramer, of the hospital staff, was recruiting doctors and nurses from wherever he could, and it still wasn't enough.

It is very difficult indeed to describe this extraordinary and traumatic situation.

Mr. Chairman, at this time, I would like to enter into the record statements by the hospital and M.A.O. staff describing in more detail than I have time to, what it was like.[1]

Mr. Chairman, I would also like to bring on Mr. Adamovich and introduce Mrs. Lavetta Pearson, director of the Abbott-Northwestern/M.A.O. Senior Citizens Clinic, Mrs. Judy Lampert, R.N. and personal assistant to me, and Dr. Roger Farber, neurologist and a board member of Community Medical Associates, who will give their impressions.

I would ask Mr. Adamovich to describe this period. Lavetta Pearson is the director of the Abbott-Northwestern senior citizens' clinic and she is also personal assistant to me. She does not like to be called a volunteer but let's put it this way: She does not get paid for her many hours of volunteer time, and Dr. Roger Farber, a neurologist and board member of CMA. George?

STATEMENT OF GEORGE G. ADAMOVICH—Continued

Mr. ADAMOVICH. Mr. Chairman, in working with M.A.O., we learned of the seriousness to the seniors of the deductible and coinsurance features of the Medicare program and the resultant failure of many seniors to obtain needed medical services. Many senior citizens frankly admitted they thought Medicare would pay their medical bills and were bitterly disappointed when this was not true. While M.A.O. became critically aware that the cost constraints for most seniors were a major disincentive to obtaining necessary medical care for a significant number of seniors, we could only speculate as to the scope of this problem. We at Abbott-Northwestern discussed with M.A.O. the possibility of accepting Medicare payments as total payment for all health care provided by the clinic and the hospital.

[1] Retained in committee files.

On the side of proceeding with such a policy was the obvious need, although the real magnitude of this need was unknown. We feel strongly that hospitals, as the community's largest—if not only—organized health care resource, must take initiative and assume some risk in defining health care needs and developing programs to meet these needs. It was clear to us that Medicare was not doing the job, as widely believed.

Also, on the plus side, in terms of economics, was the probable increase in hospital inpatient business and other ancillary services that would result from hospital participation in such a clinic program. Inpatient days throughout the country are declining for various reasons. All of which tend to increase the cost per patient day; to any new source of business that would increase our patient days would tend to reduce the cost per patient day, which is terribly important when considering the social, political, and legal constraints we are under to hold the line on increasing costs.

On the negative side of going ahead with a free service pricing policy, were the obvious costs of absorbing the deductible and coinsurance features of Medicare, plus the cost of providing remodeled space for an expanded program. We had no way, of course, of accurately estimating either the increased revenue or increased expenses, but we attempted to do this and, with board approval, decided to proceed.

An M.A.O. newsletter announced that the expanded program for the senior citizens' clinic which would offer non-Medicare-covered services at no cost would begin on November 1, 1973.

In conjunction with the new pricing policy, Abbott-Northwestern agreed to remodel space in a building across the street from our emergency room, freeing up a congested emergency room and giving the Abbott-Northwestern/M.A.O. Senior Citizens Clinic a home of its own.

Mr. Chairman, it is difficult to describe the impact that the announcement of a senior citizens' clinic, accepting Medicare as full payment for primary care, had on our community and the hospital.

To say we were surprised and overwhelmed by the response to this announcement would be a gross understatement. To give you an understanding of this, let me tell you something of the impact of the clinic on Abbott-Northwestern.

Prior to November 1, 1973, the senior citizens' clinic was seeing 20 to 30 patients a week. During April 1974, the average number of patients seen during a 7-day period, either in the clinic or the emergency room, was 249.

The number of registered patients grew from less than 1,000 enrolled to almost 10,000.

Program Impact Felt

The impact of the senior citizens' program after November 1 was understandably felt by most hospital departments. In April 1974, the total revenue of all departments attributed to the senior citizens' program was $97,000, or 3.6 percent of the corporation's revenue.

In terms of the actual utilization of services, hospitalized M.A.O. patients accounted for 5.4 percent of our average daily census from

January through April 1974. This represents approximately 35.5 M.A.O. patients being served on an inpatient basis on any given day.

As we provided care to these patients, we became increasingly aware that many of them had, for a number of reasons, held off seeking badly needed care. Between 10–15 percent of the patients were classified upon "intake" to the clinic as requiring immediate medical attention by a physician. Approximately 8 percent of the patient visits resulted in hospitalization of the patient. It is not an overstatement to say that our professional staff was "shocked" by the extent of pathology present in these patients and the fact that many had not been receiving care for their conditions.

I have already indicated the severe condition of many of the seniors seen in the clinic. Let me address this from another perspective. Data assembled by the Governor's Council on Aging indicates that on an annual basis, there are around 364 hospital admissions per 1,000 Medicare enrollees in Minnesota.

In comparison, we are experiencing in excess of 500 hospital admissions per 1,000 active patient-enrollees of the clinic. We feel the lesson is dramatic—there are many senior citizens in acute need of medical care whose physical conditions continue to deteriorate because they cannot afford medical care, even with Medicare. By removing the financial barriers, as we have done, the people not only seek care, but far exceed our present capabilities to adequately respond to the needs.

There is pressure nationally to reduce the number of acute care hospital beds. This appears on the surface desirable. On the other hand, wouldn't we, as health professionals, and as a nation, look ridiculous a few years from now, if after reducing the number of hospital beds, we found a large unmet need for these beds and had to replace them?

I am convinced that unmet need in the elderly population and among other age groups of the poor and near poor, would appropriately and fully utilize available health facilities in any metropolitan area of the country if financial barriers to care were eliminated.

We have reviewed a number of interesting statistical relationships. These do not fully display the human drama that every responsible department head in our hospital experienced. Some of their statements will be introduced in evidence.

Hospital Workload Increased Greatly

For example, the chief in our electrocardiogram and electroencephalogram department reported her shock in doing 250 EKG's in a single weekend compared to a normal load of 20.

The chief administrative laboratory technologist at the Abbott Division reported that our laboratory had an annual increase in volume of 10–15 percent, but since November, that percentage tripled. Of particular interest was the alarm she expressed at the number of abnormal test results.

A staff nurse in the clinic reports that the people she sees had a severe deterioration in their physical condition, and added that the frustration of working in this clinic is that there is so much to be done and not enough time.

The acting clinic director at the time the clinic expanded, very graphically describes in her statement both the kinds of patients seen

with severe illness, and the tremendous organizational challenge of a rapidly expanding clinic program.

The assistant chief X-ray technologist reported nearly a 50-percent increase in activity in his department in the first week, and that the X-rays generally showed considerable pathology.

The director of medical records reports the enormous growth in her department from one girl handling all clinic charts on a part-time basis to a separate full-time staff of four. The challenge of orienting a large, new staff is obvious.

The director of nursing graphically describes the impact on staffing the nursing service department to accommodate a large volume of acutely ill senior patients with multifaceted medical-surgical problems.

The chief pharmacist and his associate assigned to serving the senior citizens' clinic testify to the enormous added volume of prescriptions resulting from the growth of the clinic. Their concern for the well-being of this population has led them to propose the assignment of a clinical pharmacist to work as a team member in the clinic to assist in assuring that compatible medications are prescribed to the patients. To that end, they have secured enthusiastic letters of endorsement from Hugh F. Kabat, Ph. D., professor and head of clinical pharmacy, and Lawrence C. Weaver, dean of pharmacy, both of the University of Minnesota. These letters of support will be introduced for the record.[1]

Our greatest challenge in getting the clinic off the ground has been and continues to be, an adequate supply of physicians.

Senior Citizens Clinic Staffing

I. Physicians:
4 FTE based on 60 hour work week.
6 FTE based on 40 hour work week.

II. Clinic staff:	*FTE*
Director (RN)	1.0
Registered nurses	4.0
Licensed practical nurses	2.0
Referral nurses	.5
Emergency room nurses (RN's)	1.0
Medical record clerks	4.0
Admitting clerks	1.0
Billing clerks	3.5
Clinic secretary	1.0
Scheduling secretary	1.0
Total	19.0

M.A.O. INPATIENTS AVERAGE DAILY CENSUS SIGNIFICANCE OF AVERAGE DAILY CENSUS OF M.A.O. INPATIENTS

	M.A.O. ADC	ABB-NWH ADC	M.A.O. ADC as percent of corporation ADC
January	30.5	648.7	4.7
February	32.8	654.6	5.0
March	35.9	652.2	5.5
April	43.1	686.9	6.3
May	43.0	652.0	6.6
Cumulative (151 days)	37.1	658.8	5.6

[1] See appendix, item 5, p. 1320.

CLINIC REVENUE AND PRESUMED UNITS OF PRODUCTION

	Senior citizens' clinic revenue as percent of corporation revenue	Units of production [1] compared Jan.-April YTD for 1973-74 (in percent)
Medical-surgical	2.8	1.5
Emergency room	9.8	8.6
Radiology	8.0	6.9
Laboratory (includes EKG)	7.5	21.8
Pharmacy	5.6	13.7
All departments (corporation total)	3.6	

[1] Most departments do not identify patients as to source; so a count of M.A.O. patients and procedures performed for them is not available. Most departments are presuming that the increase in activity in 1974 over 1973 is attributable to M.A.O. patients.

The announcement of this clinic, it is fair to say, created a number of shock waves in the medical community. It is to the credit of the Hennepin County Medical Society, and particularly to key physicians in each of our hospitals' medical groups, who formed the organization called Community Medical Associates (CMA), that we were able to overcome many of the initial reservations concerning the program and move ahead. Dr. Roger Farber, M.D., who will testify today, is a member of the board of CMA.

It would not be appropriate to discuss the impact of this program on our hospital without touching on economic issues implicit in the program. The statement I most often hear is that we must be "making money" from these additional Medicare patients. I would like to emphasize categorically that no one can make a profit, or for that matter even a reasonable net gain, for maintaining equipment and facilities, from Medicare patients.

In a nutshell, Medicare pays either allowable cost or billed charges, whichever is lower. This means that if you underprice your services, you will lose money; if you price your services above cost, Medicare will discount its payment. This is essentially true of Blue Cross patients as well, which, together with Medicare, accounts for 60 percent of the hospital's revenue.

A key question we are also asked regularly is: "How can the hospital afford to absorb the deductible and coinsurance costs of Medicare?" We have recently completed a preliminary report on the financial impact of the senior citizens' clinic on Abbott-Northwestern for the first 5 months of 1974. The clinic had billings of approximately $800,000, of which $600,000 represented inpatient care and $200,000 represented outpatient care. If clinic patients pay their full share of overhead, based on "full cost" cost accounting, the loss on the operation of the clinic program—inpatient and outpatient—would approximate $267,000 for the 5-month period.

However, as long as the number of inpatients generated from this program are not enough to require a material change in staffing patterns, and do not displace any charge-paying patients, it has been been possible for us to produce a revenue of approximately $100,000, in excess of that required to offset losses sustained in providing outpatient services, and, which will partially offset the capital requirements for developing the clinic and related supportive services.

It is important to remember that clinics organized in this financial pattern are practical only on a limited or experimental basis. In no way can we assume that all hospitals are capable of accepting Medicare as full payment. What must be done is to correct deficiencies inherent in Medicare so that providers—doctors and hospitals—can be fairly reimbursed for services they provide to senior citizens.

There is no question that the complexity of such a program, the capital investment necessary to deliver the service, and the many uncertainties and variables in estimating financial impact are major roadblocks to most health care providers who might be interested in experimenting with such a program.

Case Histories Cited

Mr. Chairman, I would like to take a few minutes now to review with you several actual case histories taken directly from patient records of the senior citizen clinic. I believe these cases are most representative and will dramatically illustrate (1) the magnitude and scope of pathology present in many of the patients seen at our clinic; (2) the fact that many acutely ill seniors, for one reason or another, hold off seeking badly needed medical care; and (3) some problems inherent in our present Medicare program.

Since November, we have seen several thousand patients at the Abbott-Northwestern/M.A.O. Clinic. While time constraints have prevented us from reviewing all of these charts prior to this hearing, we did pull what we think is a representative sampling of charts for detailed review. This sample consists of 72 complete patient records.[1] In order to preserve confidentiality we have removed all patient identifying information from these records; however, a case number has been assigned to each chart which, if necessary, will permit reference to the original records. For purposes of illustration, I would like to refer to nine of these cases today.

A significant portion of people coming to the clinic are in immediate need of medical care. Overall estimates made by our medical staff indicate that approximately 10–15 percent of the clinic patients require the immediate attention of a physician; and approximately 8.1 percent of the patient visits to the clinic subsequently result in hospitalization. Also, for the period of November 1973 through May 1974, 25 percent of the patients seen required specialist referral.

The following cases are very typical of the medical condition of many patients treated at the clinic:

(1) A 65-year-old woman came to the clinic complaining of a crushing chest pain, that she was having difficulty breathing, and had indigestion. The examining physician, recognizing immediately that the patient was in critical condition, administered oxygen and had her admitted to the coronary care unit. The patient, suffering from shock, a massive heart attack, and the rupture of a ventricular aneurysm, however, died within a few hours. (Case No. 153.)

(2) A man 72 years old who had not seen a physician in 6 years was concerned that during the previous 2 to 3 weeks he had occasionally

[1] Retained in committee files.

experienced black stools and stomach pains. Examination and testing revealed that the man's colon was completely obstructed by a mass. . . . He was admitted to the hospital where he later underwent a colon resection operation because of cancer. (Case No. 159.)

(3) Another man, 73 years old, came to the clinic complaining of shortness of breath and difficulty in breathing. He said he had been in good health up until 2 months previously. Examination and testing revealed that the man was suffering from arteriosclerotic heart disease, pulmonary emphysema, acute bronchitis, and that he had a borderline hypothyroid condition, and was suffering from depression. Following the visit, he was subsequently hospitalized twice and placed on medications. (Case No. 103.)

(4) A 76-year-old man with a history of angina, high blood pressure, and occasional chest pains was seen at the clinic in January of this year for a routine history and physical. The examination confirmed he was suffering from arteriosclerotic heart disease with angina pectoris, hypertension, and had glaucoma. The next month, he was not feeling well and returned to the clinic, where he collapsed. He was immediately hospitalized in the cardiac unit and treated for acute atrial fibrilation. (Case No. 140.)

(5) A 74-year-old female came to the clinic complaining of a persistent cough, recurrent skin infections, and a noticeable change in bowel habits. Examination by a clinic physician found her to have rectal cancer, high blood pressure, mild heart problems, anemia, and developing cataracts. About a month later she underwent surgical treatment for the cancer. (Case No. 141.)

Many Ignore Symptoms

I emphasize that these patients are typical of many patients seen in our clinic—they suffer not only from severe medical problems, but a multiplicity of severe problems. More importantly, the patient has often held off seeking care in spite of noticeable, abnormal symptoms; and frequently the patient has not recognized unusual symptoms as potentially serious or even fatal. The following four cases are intended to illustrate this:

(1) A 72-year-old lady came to the clinic with a minor complaint. The physician elected to complete a routine history and physical. This examination revealed numerous health problems including a "suspicious" area in her breast, arteriosclerotic heart disease and angina, hypertension, a cataract in one eye and, hypothyroidism. The suspicious lump proved to be cancerous, and the woman underwent a radical mastectomy (case No. 105).

(2) A man, 70 years old, presented himself at the clinic complaining of having difficulty swallowing. While examinations did not reveal the reason for this particular condition, the patient was discovered to also have high blood pressure and a "heartblock," resulting in the implantation of a cardiac pacemaker (case No. 109).

(3) There was another lady, 65 years old, complaining of intermittent diarrhea and constipation, abdominal discomfort, and a vaginal discharge problem which had seemed to get progressively worse over the past year. For some time, she had "treated" herself for

this condition using cortisone cream, but this wasn't helping. Examination revealed that the woman was suffering from an abdominal aortic aneurysm; she subsequently underwent surgery (case No. 149).

(4) An 80-year-old female came to the clinic complaining of headaches, nervousness, and what the medical chart describes as a "huge number of vague complaints." Examination in this instance revealed the presence of mild congestive heart failure, hypertension, and a mass in the pelvic region. The patient was subsequently hospitalized for a number of months, undergoing surgery to repair a bladder problem, and other medical treatments (case No. 150).

These four cases illustrate a vital issue concerning Medicare coverage and, hopefully, will suggest a guideline for the future development or expansion of health insurance programs.

Wherever there is the slightest indication that the examination of a patient includes routine health screening, the medical services provided will not be paid by Medicare. Basically, under Medicare, health screening, and more fundamentally, preventive health care, are noncovered services. It seems incredible that such a position should be taken in a period in which health maintenance, as a policy, has been given national recognition.

The above cases portray the vast discrepancy between a patient's perception of his own health status and the reality of his condition. Each of us can only guess why this is so. However, it becomes abundantly clear that effective diagnostic screening is consistent with good medical practice and essential to verifying the presence or absence of disease.

It becomes obvious that proper diagnostic screening as part of an overall health maintenance program can contribute significantly to the early detection of disease, the prevention of unnecessary death, and, consequently, to the quality of life.

One might speculate that adequate coverage for diagnostics might have reduced some of the misery experienced by the four patients described above. At the same time, we know for a fact that most patients seen in the senior citizens' clinic program cannot afford to pay for any health services above Medicare coverage.

It should be emphasized that I am not describing mass screening—the value of which is still being debated. What I am suggesting is that selective screening, consistent with the age and general condition of the patient, as ordered by the patient's physician, is most desirable.

Surely one can build a solid case for the economic advantage to the taxpayer to treat disease early, avoiding some costly surgery, hospitalization, and possible institutionalization. It is to this end that I recommend that Medicare laws be changed at the earliest possible date to insure our senior citizens the right to health maintenance services.

Mr. Chairman, in my earlier testimony I discussed a number of the problems relating to Medicare reimbursement.

The attitude reflected by the supervisor at Blue Cross is most unfortunate. It is most significant in illustrating that the regulations for interpreting Medicare are sufficiently complex and lacking clarity so as to permit such an arbitrary and capricious posture.

As yet we have not appealed these claims to higher officials in the Blue Cross organization. We are confident that the claims will have a

fair hearing at that level. What is regrettable is the time and energy expended in this process.

Once again, I would like to underscore the fragmentation and complexity of the claims payment system, making it vulnerable to misinterpretation at the expense of the insured patient. The lack of coverage, especially in the area of preventive and diagnostic medicine, is a glaring deficiency. For that reason, I agree with the observations of Dr. Eveline M. Burns, professor emeritus, Columbia University School of Social Work, who, in her book "Health Services for Tomorrow—Trend and Issues," said, and I quote:

> An orderly organization for the provision of health services would include coverage of all health needs from prevention to rehabilitation, the assurance of continuity of care, the avoidance of duplication of coverage or overlapping, and the prevalence of knowledge as to what is available and where to get it.
>
> The more importance we attach to this objective, the more we shall surely move away from the item-by-item approach where separate units or types of care are identified and paid for with public funds while others are not.
>
> No word has appeared more frequently in medical literature and in health conferences in recent years than the word "fragmentation," and it has been used as a term of abuse. The item-by-item approach adopted in title XVIII can only intensify that fragmentation.
>
> But more is needed than avoidance of intensification of fragmentation through our public programs, important as this is. Given the existence of both public and private operation of a great variety of health programs and services, a situation we shall face in this country for many years to come, there is a crying need to create a structure whereby some central health planning agency or council, on the community, state, and federal levels, is given the responsibility for looking at the provision as a whole, is given the authority to do something about it, and is adequately financed to do the job.

It is no small concern to us, who are responsible for providing health care, that the country is heading rapidly toward a program of national health insurance, and that it may be patterned after Medicare. No greater disservice could be done to the American people than to build in, for all Americans, the inadequacies of the present Medicare system. In this context I must once again agree with Dr. Burns, who said:

> The more we are concerned with a national organization of health services, the more we shall question the wisdom of the use of the private intermediary, especially the profitmaking insurance companies. Unless their functions are very narrowly confined to the mechanics of paying bills, and it does not look as if they will be, their existence as an integral part of the administrative structure can only complicate the task of community planning. They are not community-based or community-oriented. As fiscal agents paying on an item-by-item basis they are unlikely to be concerned with the appropriateness and adequacy of available services. At best they create yet one more agency that has to be brought into the planning process.

To me it seems crucial that the private agency designated as fiscal intermediary have no responsibility for determining the standards for quality of care. Unless this authority is vested in a separate appropriate agency, we can expect that our definition of quality care will be tailored to available dollars and not necessarily in the public interest.

Let us turn once more to the specific issues which face us in the delivery of health services to senior citizens. For the period November 1, 1973, to March 31, 1974, Medicare rejected 454 claims totaling $41,000. These rejections related to hospital services provided to senior citizens on an outpatient basis. All inpatient services were paid, except, of course, the deductible and coinsurance.

We know that some of these billings were correctly denied because for a few initial weeks the clinic performed some routine screening examinations before the patients were seen by a physician.

Of major concern to us is the reimbursement to Community Medical Associates, which only amounts to 40.3 percent of billed charges. Obviously, CMA could not stay in business if the hospital did not assume most overhead costs.

Beyond the economic considerations we must examine the desirability of such a venture within the changing role of the hospital and the changing social environment. Central cities throughout the country are in jeopardy as they see their facilities become outdated, as the neighborhoods in which they are located deteriorate, and as they see their occupancy and revenue decline.

The central cities of America cannot afford to lose their hospitals. In the urban areas it is these institutions which can provide the backbone to revitalize citizen interest in their communities and organize the resources needed to meet the health care needs of the community.

These realities mandate that we explore alternative mechanisms for making health care accessible, and explore new roles for the hospital, new relationships with citizens, and new ways of organizing health care resources to deliver care, if we are to be effective stewards of our public trust.

New patterns of health care must include an effective partnership of health and human services to maximize health care delivery while minimizing cost. Components of such a system are described by Senator Kennedy in his book, "In Critical Condition—The Crisis in America's Health Care," as available to senior citizens in Britain's health care system. The Minneapolis Age and Opportunity Center's comprehensive program provides a unique example in this country of such an approach.

In our annual report for 1973, the then chairman of the board, Charles S. Bellows, underscored the following concerns:

> Unless those in Washington who write our health care laws and devise and administer reimbursement formulas under a national health insurance system permit us to generate and retain a reasonable return to meet demands for plant and equipment, we will be financially forced into mediocrity and perhaps eventual demise.

He went on to say:

> * * * we intend to work and fight for continued excellence in our health care system.

Mr. Chairman, we would like to enter for the record the 1973 annual report of the Abbott-Northwestern Hospital, Inc.[1]

Mr. Chairman, I would like to thank you and the committee for permitting us to share with you the story of the Abbott-Northwestern Hospital/Minneapolis Age and Opportunity Center Senior Citizens' Clinic.

Mrs. KRAUSE. We will now hear from Lavetta Pearson.

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[1] Retained in committee files.

STATEMENT OF LAVETTA PEARSON, R.N., DIRECTOR, ABBOTT-NORTHWESTERN HOSPITAL, INC./M.A.O. SENIOR CITIZENS' CLINIC

Mrs. PEARSON. My name is Lavetta Pearson, and I am presently employed as the clinic director of the Abbott-Northwestern/M.A.O. Senior Citizens' Clinic. In 1954, I graduated from the Abbott Hospital School of Nursing. Since that time, I have worked as a registered nurse in different hospitals and in various capacities, such as evening supervisor, private duty, and the intensive care unit. I have been working at Abbott Hospital since 1964 and I assumed the position of clinic director on February 11, 1974.

If I may, I would like to relate to this committee a personal story. When I was working as an evening supervisor at Abbott Hospital, I saw very little of my husband and son. I requested that the hospital transfer me to a daytime position because I wanted to spend more time with my family. Abbott's administrator, George Adamovich, asked me if I wanted to work with the Minneapolis Age and Opportunity Center and Clinic. I decided to accept the job because I could work during the day and thought in a matter of a month I would find myself in the role of an 8-hour clinic director and in charge of a smooth-running clinic.

Since I have assumed my position, my hopes for a comfortable 8-hour-a-day job have vanished and my job has had a deep impact on my life. I have been forced to work 10 to 12 hours a day, and I have seen the examination rooms in the clinic expand from four to nine. I have seen my staff grow from 8 to 20 full- and part-time people, and I have seen a clinic that operates 7 days a week. In spite of this enormous growth in such a short period of time, it still does not meet the needs of the senior citizens in our community.

Perhaps the greatest impact that this job has had on me is the revelation of the enormous need of medical health care by senior citizens. I have seen thousands and thousands of senior citizens coming to our clinic with gross and serious pathologies. I have seen a number of senior citizens with high blood pressure, uncontrolled diabetes, malignant cancer, impaired vision, cataracts, and pulmonary problems. You can almost cry by the time you get done reading their charts.

It has shocked my conscience and what ought to shock the conscience of all Americans is the fact that many of these senior citizens have not seen a doctor for periods ranging from 1 to as many as 50 years. Upon inquiry why they haven't seen or sought any medical attention, the answer invariably is they did not have the money, or they did not know whom to go to or how to get to the doctor's office. As one senior citizen clearly stated to me, if you only have a limited amount of income and you have to choose between buying pills and food, you are always going to buy the food.

ENORMOUS NEED FRIGHTENING

It is just unbelievable and frightening to see the enormous need that these senior citizens have for immediate medical treatment. Let me cite an example of a type of patient that comes into the clinic. The other

day, a senior citizen came into our clinic with acute hypertension. He proceeded to have a heart attack in the clinic. We admitted him immediately to the intensive care unit. Frequently we do need to admit a patient from the clinic to the hospital during clinic hours. Due to the severe medical problems of some patients, our clinic doctors make numerous referrals to specialists in areas as eye doctors, ear, nose and throat, neurology, dermatology, and podiatry. With the type of pathology we see, we have referred patients to specialists in all areas. The referral doctors have been very cooperative and generous about taking our patients immediately.

The average days at the clinic are always hectic and usually we have crisis after crisis. Even before we open the clinic, patients are already calling and demanding to see a physician. They know they will have trouble getting through later in the day. Seniors call all day to seek advice, to have prescriptions filled, and to get appointments. We started with two patient telephone lines; we now have four lines and these lines are constantly ringing all the time.

On the average, we see about 40 patients per day. We should be seeing more, but we do not have the physicians. I would like to have them; all the people who call see a doctor. I'd like to be able to tell them to come in, but I just don't have the physicians to do so. Consequently, that puts us in the horrible position of choosing between sick and acutely sick people. No nurse or doctor should be placed in the untenable position of trying to make those choices.

The doctors in our clinic are already under a very heavy caseload and heavy pressure because of the large amount of patients that they are scheduled to see and the large number of walk-in patients that come off the street without appointments. I'd like to adhere to the philosophy that if a patient is ill, he or she must see the doctor, but this is not always possible.

I have the doctors say to me, "Mrs. Pearson, in order to provide quality care, I cannot see that many patients. I can't see them that fast, and if I try to, I just can't do a decent job." I must tell this committee that I am putting the physicians' statements in a very mild manner, but I have been told in very strong and serious terms. My staff all work very hard. They have to; there is just no other choice.

I would like to point out that our clinic has greatly increased the workload of all the departments of Abbott, especially pharmacy, lab, X-ray, and the outpatient emergency room. All these departments have risen to meet the challenge of delivering health care to these senior citizens.

As clinic director, I am confronted with several enormous, pressing, and crucial challenges. First, there is the challenge of supplying quality health care to the senior citizens that come to our clinic. I always insist and demand that quality health care is delivered to our patients. This is in keeping in the tradition of Abbott Hospital, my staff and the physicians that work at the clinic. Sometimes this becomes very difficult because one must balance the quality of care and the delivery of medical services to a tremendous—and I mean a tremendous—number of people that are in need of medical attention.

Additional Physicians Needed

My second challenge is to find more doctors to staff the clinic in order for us to increase the number of patients that we can see. I can't impress upon this committee enough that it would mean just everything if we could hire and obtain more doctors. We have an immediate need to hire four or five new physicians. We are trying very hard to meet the physician void, but there just seems to be a shortage of doctors. If we could obtain the necessary doctors, we could increase our patient load, and we could realize and deliver quality and continuity of care for all our patients.

Third, I am confronted as the clinic director with the challenge of and concern about finances. Finances for me and the clinic have been a terrific and frustrating headache. I have had to become involved with the problem of reimbursement and Medicare. I cannot truly relate to you the number of hours I have spent researching Medicare rejects, trying to figure out why claims have been rejected, what we can do in the future to correct whatever deficiency we have on our forms that we are presently submitting to Medicare. In the beginning we submitted the regular Medicare forms, as do all other health care facilities. Because of continuous rejects of these claims, we began sending to Medicare not only the required Medicare forms, but also duplicate copies of our own clinic billing information slips. On these forms, doctors and nurses supply information as to diagnosis, specific tests ordered, and reasons for ordering them. I would like to reemphasize to this committee that our clinic is supplying to Blue Cross this information and they are still rejecting our claims. At times you get the feeling that Medicare, and Blue Cross in particular, are making it very difficult for us to provide quality health care, by requiring us to unreasonably justify the delivery of medical care to our sick elderly patients. It just seems unfair the reaction that Medicare has had to our clinic. I feel, and the doctors on our staff feel, that these tests and procedures ordered are necessary for doing quality care, and there aren't any patients who come to our clinic that don't have justifiable symptoms.

I would not like to think that all the Medicare rejects I receive back on my desk are due to the extra paperwork we have created for Blue Cross, Medicare or whoever screens them. However, in some of my conversations with Medicare, the rejections we have been receiving, and considering the fact that these claims were paid before our expansion, it seems that is exactly what their reaction is.

As I was looking through stacks of Medicare rejects one day, I asked our primary clinic physician if he had any problems with reimbursement before the expansion of the clinic. He said no. I then asked him if he had ordered the same tests and procedures then and he said yes, he had, because it was absolutely necessary to do these tests and procedures in order to treat these patients efficiently. It is impossible for me to understand why these same tests and procedures are not covered now. I don't believe the laws have changed significantly. I have personally compared some of these Medicare forms and I just truly don't understand why they were paid at one time and presently are

being rejected. It just totally infuriates and angers me. We should be concentrating on providing health care to these people and not spending an unreasonable amount of time working on problems of reimbursement.

Finally, our clinic must meet the challenge of providing comprehensive quality health care to our patients. The uniqueness of our clinic is due to the relationship with the Minneapolis Age and Opportunity Center and their offering of supportive services. This relationship provides our clinic and our physicians with many options on how to care for patients. By integrating these supportive services with the health needs of our patients, we are able to treat the whole person rather than just the body.

I am hopeful that the information and thoughts we are bringing you today will be helpful in formulating positive legislation that will meet the medical needs of our senior citizens.

Mrs. KRAUSE. Mr. Chairman, Judith B. Lampert.

STATEMENT OF JUDITH B. LAMPERT, R.N., ASSISTANT TO EXECUTIVE DIRECTOR OF THE MINNEAPOLIS AGE AND OPPORTUNITY CENTER, INC.

Mrs. LAMPERT. My name is Judith B. Lampert. I reside in Wayzata, Minn. I am a registered nurse and assistant to the executive director of the Minneapolis Age and Opportunity Center, Inc. (M.A.O.). I have been working with the M.A.O. program for approximately 2½ years. I graduated from the New York University-Bellevue nursing program in 1961. The clinical experience for that program was Bellevue Hospital and the New York City Visiting Nurse Service. Following that, I returned to Minneapolis and did graduate work in nursing education at the University of Minnesota and worked part time. Since that time my professional experience has been working part time in surgery at Northwestern Hospital for 6 years, and working with M.A.O. for the past 2½ years, primarily in the clinic setting.

My initial contact with the M.A.O. clinic was a little over a year before it expanded. It was a great experience. At that time most of the people we were seeing had definite medical problems and a need for the multidiscipline approach of M.A.O. The comprehensive services were available to our patients. Actually, the clinic is a service of the agency, not the reverse as is true in most clinic situations.

For the first time in my nursing career I was truly being able to give comprehensive care to people. I had been taught from my earliest courses that the goal of nursing care was to "treat the patient as a whole" and to provide "excellent comprehensive care."

After the announcement of the expanded clinic was made the response was overwhelming, to put it mildly. Because of my background in nursing, I screened incoming telephone calls that I received so that people with acute-sounding problems could be seen promptly—unfortunately, this could not be done for all calls. It was frightening to think of what was walking around untreated.

Then came phase 1. The purpose was to make at least a superficial assessment of the clients' health history and present problems, their economic situation and needs. I personally learned a lot. I was terribly naive and protected. I knew there were deductibles and coinsurance factors in Medicare coverage, but I had never, in my mind, related that to a monthly income of $200 to $400 and the price of rent or owning a home and food. The people we are seeing are in the most difficult position of all. They are just barely making it. They have no money left after food and shelter for anything extra—including medical care and medications. These days reminded me of the times that I went out with the Bellevue disaster unit. We were like the triage group quickly assessing needs and categorizing the litter cases and the walking wounded. Some of the things we found here were people with severe chest pain, shortness of breath, and poor color, bleeding in various ways, coughing up blood, et cetera. Obviously, in these interviews, we weren't able to pick up the asymptomatic things like aneurysms and many of the longstanding problems that these people had learned to accept as a fact of life. It's no surprise that they don't get medical care. While they are deciding whether they are about $100 sick, their condition is deteriorating. This creates the kind of situation that is exemplified by one of the patients who knew that she should seek help for her problem but couldn't afford it. Then one day she had a traumatic injury to her finger which required removing some imbedded pieces of metal and suturing. She came to us. During her finger repair, she talked to the orthopedic surgeon about her other problems that were not acute enough in her estimation. As a result of her discussion, tests were ordered and within a few days, she was hospitalized for surgery of a large rectal cancer. There are many, too, who have seen a physician and have had their problems diagnosed, but can't afford to continue their care. Our patients aren't coming to the clinic for an afternoon outing—they are sick.

The interviews were a real shock to all of us. We saw people who were well dressed and well groomed who didn't look like they needed this type of thing. Here were hundreds of people with severe medical needs who could not afford to see a doctor or continue treatment that had been prescribed. Some were in such bad condition that they could hardly be interviewed.

Some of the nurses that I worked with during these days became emotionally exhausted by the numbers of people with multifaceted, severe problems. My personal reaction at this time was disbelief—I had erroneously thought that these problems were unique to the Bowery bum.

It's interesting to see people's attitudes change with exposure to the program. One of the nurses who did intake interviews did an about-face in attitude after her first morning. Initially she thought that it was an unnecessary financial burden on the hospital. Then she met the people who were coming in for care. There was no other way for them to receive ongoing care. We talked about the alternatives to this cost and decided that from an overall point of view that it was an investment in independence that would have great dividends from both a human dignity point of view and financially. We all knew that there

were needs. We just didn't realize that there were so many. Most of us who are working don't take time to think about the state of many people who are retired.

Most of our people worked or were housewives who lived comfortably and who thought that they had provided for their retirement. They weren't derelicts or the chronic welfare group. They were contributing members of society. They are proud of themselves and what they have done. There is one exception that comes to mind—an 80-year-old retired dentist who initially said that he was a mechanic because he was ashamed of his situation. It took a long time for him to tell me that he had been a dentist. He told me of how he had done work at no charge during the depression to alleviate pain. Now he needed help.

Majority Have Major Problems

Not all of our patients have heart attacks and strokes in the waiting room, but an occasional one does. Not all of our patients have terminal cancer, some do. But the vast majority of our patients have major medical problems in the form of high blood pressure with and without the results of untreated disease and diabetes in various degrees and stages of progress. And yes, there are cases of cancer, severe kidney disease, leukemia, anemia, and the full spectrum of human illnesses. If left untreated, the fortunate people will die.

The majority, though, will become disabled and will be put in nursing homes. The financial and human costs of this course of action are high. Again comes the financial consideration. Because of the economic levels of these people they quickly are put on welfare and Medicaid. Then there is the subject of nursing home care, standards, and quality that has been discussed by many groups. Also add the humiliation of these people who are put on welfare and taken from friends and families to be institutionalized. It seems to me that this is a terribly expensive, inhuman way to handle the situation.

Medical care of the traditional physician-nurse-office-hospital variety is not adequate to meet the needs of this group of people. To adequately serve them there must be continuity and cooperation between the medical disciplines, counseling, and supportive services. It requires a nurse to be aware of the whole person—it allows the nurse to follow through and be sure that suggestions are implemented. We are doing this for our patients by using available community resources and supplementing services that are not otherwise available. It is a team approach. All of us in the clinic are strongly committed to the agency concepts or we wouldn't work there.

I see the M.A.O. approach to the problems of aging as a very viable, effective way to economically cope with the increasing number of senior citizens while allowing them to maintain their dignity. Obviously, our form of providing this help is palatable and acceptable to these people or we wouldn't have so many coming to us. It isn't welfare. It is help to maintain independence.

If the goal of medical care is to help them maintain their independence, then a coordinated, multiservice agency, such as M.A.O., with a well-trained staff, is essential.

Mrs. Krause. Mr. Chairman, Dr. Farber.

STATEMENT OF ROGER FARBER, M.D., BOARD CERTIFIED NEUROLOGIST, MEMBER OF BOARD OF DIRECTORS OF CMA

Dr. FARBER. I am Roger Evan Farber, M.D.; I reside in Edina, Minn. I am a neurologist with an M.D. degree from the University of Pennsylvania in 1963. I received my internship in medicine at the Buffalo General Hospital from 1963 through 1964. I spent 2 years with the U.S. Public Health Service National Institute of Health from 1964 through 1966. I served my residency in neurology at the University of Pennsylvania, 1966 through 1969, and received my board certification in neurology in 1972. I am a member of the American Academy of Neurology, member of the Minneapolis Academy of Medicine, as well as the American Medical Association and the State medical association. I am an instructor in the department of neurology at the University of Minnesota. I am with the Noran Neurological Clinic in the practice of neurology and am an active staff member at Abbott-Northwestern Hospital in Minneapolis, Minn.

During the first years of functioning of the multidimensional M.A.O. program, it became very apparent that a large segment of the people in our community were not availing themselves of private or public medical care. We have become involved with this heretofore unreached population, the "new poor." The reasons and the consequences have become apparent. Private medical care seemed unaffordable to our fixed-income senior citizens because they could not meet the deductibles and the unpaid or coinsurance part of the doctor and hospital fees. County care was abhorrent because of the traditionally dehumanizing image it has held to people who have watched these institutions for the past 50 years. Furthermore, the county often required relinquishing whatever financial holdings a person had, before accepting them for free care. The result of this hesitancy to avail one's self of existing services, even when transportation and other ancillary services have been offered, had that been our older folks do not get preventive care or early intervention. They only go to a doctor in many cases, when "it is too late," or end up in expensive nursing homes when they could have been kept independent.

One of the most tragic examples of this hesitancy to avail one's self of care was a letter that we received a few weeks ago. A husband wrote that his wife had been failing for a long time, but only now that he heard of our program did he feel that he could afford a doctor. He asked for an early appointment, and it was granted. His next communication read: "I don't know whether you have answered my letter yet, but never mind. My wife died."

To answer these needs, we established a freestanding private care corporation which we have called Community Medical Associates. Members from each of the medical groups associated with Abbott Hospital became members of the board of directors, and initially, one full-time and several part-time physicians became employees of this corporation. Those physicians have been able to manage on Medicare payments because the hospital has absorbed their usual overhead costs. The consultative physicians have agreed to accept what Medicare would pay on a voluntary basis. In effect, we created an organization aimed at health maintenance, but unlike the traditional

health maintenance organization, not constrained to hold back on diagnostic tests because the project was conceived as a cooperative venture between a private hospital and a private medical corporation for the benefit of the forgotten elderly.

Gratifying Experience

I am a neurologist, and from my vantage point this joint venture has been personally very gratifying. In the first 6 months we have been functioning, I have seen more than 300 patients in neurologic consultation for the program. In my subspecialty alone, we dramatically see demonstrated those kinds of problems that only get worse with delayed medical attention. Older folks with incapacitating tremors from Parkinson's disease and other causes, with treatable benign tumors, with degenerating disc disease, with nutritional deficiencies, with chronic pain syndromes, and with impending strokes have all now, for the first time, sought and received medical care.

I am especially interested in stroke prevention, which we are now able to do by identifying patients with risk factors such as hypertension and diabetes, and by demonstrating and then surgically removing the sludged atherosclerotic plagues that are in many older people's carotid arteries.

A recent patient sent to me through the program was an 81-year-old lady who had had her left leg amputated but was managing at home with a prosthesis. She was, however, experiencing increased weakness of the left side of her body and feared she would have to move to a nursing home. She availed herself of a medical evaluation through our program, and narrowing of her right carotid artery was diagnosed and the sludge was removed. Her weakness disappeared, and she is now still in her own home, happily functioning independently.

In the past month a charming 67-year-old man of Central European extraction came to me because of blackout spells. He had refused care previously because he did not want to deplete his minimal resources and risk leaving his wife destitute, should he die. I detected a periodic complete block in the electrical system of his heart and explained to him I would have to arrange for him to have a pacemaker. "But Dr. Farber," he said, "Mr. Kissinger is so busy in the Mideast." Our friend has his pacemaker and an excellent chance of many more years to be spent with his wife.

These first two stories demonstrate what can be accomplished if we are available. The last is a tragic example of what has been going on in the past.

An 87-year-old woman came to see me because of difficulty walking which had left her in a wheelchair over a 4-year period. This patient came in, smiled, and informed me that although she was 87, her father had just died at age 102 a few years before and that her mother survived to almost 100. She herself had always taken care of all their needs and owned a very small home. She had felt that maybe her difficulty with walking was due to the lack of proper eating habits. Social Security was no longer covering all the costs involved with her housing and inflation was cutting into her food budget. She had never sought medical care simply because she could not afford the

deductible and the partial reimbursement. It became quite clear as we went over her that what had happened was a gradual but slow total compression of her lumbar vertebra and that, at the time she came to me, it was too late for any therapeutic intervention. Essentially, a preventable but now totally irreversible paralysis of a very fine spirited lady's legs had occurred.

We have all learned through the years that medical assistance alone is no panacea. This has been amply demonstrated in the many Government-funded comprehensive health care programs. Medical care must be offered within the context of the patients' total environment. The supportive system of the M.A.O. program has provided this backup. There is little to be gained in treating a very old person with nutritional deficiency if he is to return to the same food preparation and eating patterns when he returns home. By providing dietary aides, including dietitian services, home-delivered meals on a daily basis, visiting nurse referral services, homemaker assistance, and transportation when necessary for both shopping and medical appointments, patients who previously would either lapse into coma at home from lack of attention, or require permanent nursing home care, are now able to make it on their own. A once-a-week cleaning of a house, a once-a-week help with provisioning, a one- to two-times-a-month transportation, a one- or two-times-a-week nursing visit to provide shots, all may simply provide the difference between living at several times less cost than a nursing home.

Medicare Not Meeting Elderly Needs

I believe that our initial enrollment of 10,000 approximate interested eligible older people in need of care, amply demonstrates the reality that Medicare is not meeting these people's needs. Their budgets are already stressed by inadequate Social Security payments. Our current inflation, both in housing and food costs, has already rendered these people malnourished and unless their last possessions are taken from them, additional money is nowhere to be found for uncovered medical costs.

Our first 6 months have also demonstrated that the physicians providing primary medical services are able to pick up the deductibles and accept an 80-percent payment on a temporary basis only. They have managed up to this time because of the large volume of terribly ill patients being seen, whose costs far exceed the $60 deductible.

If, however, we could see all the patients who have registered in the first year—and we can't—a second year of this program by simple mathematics would prove to be financially crippling unless a new financial solution is found. If we assume that these 10,000 patients will require 1 hour apiece of medical care in their second year with the program, just to provide three 20-minute followup visits, and that within the deductible there will therefore be no Medicare reimbursement, then 10,000 physician hours or four physicians working 50 hours a week for a whole year will be required on a donation basis.

As a private consultative physician accepting the assignments, I am currently receiving less than $20 out of every $50 charged and this is with an overhead rate that is greater than $20 per $50. Let me describe a typical bill:

(1) Doctor's fee for angiogram plus four visits at $10 each equals $240; Medicare allowable fee, $210; patient pays $30 plus (2) deductible not satisfied, patient pays $60 plus (3) 20 percent patient coinsurance, patient pays $30 equals patient pays $120 of $240 doctor bill. (NOTE. If deductible has been satisfied, patient pays $60.)

It is quite clear to me, as a voluntary provider of medical services, that current funding of Medicare is grossly inadequate for patients dependent for their subsistence on Social Security payments. There is similarly no doubt that early preventive medical care with appropriate backup services to this population of patients vastly reduces the overall cost to society of their management.

The question really seems to be whether or not the American people and the Congress of the United States want to provide and adequately provide for the care of its people. It is our feeling that the current American voluntary health care system is capable of superbly meeting the needs of senior citizens but it can do so only with more adequate Medicare funding for hospital costs, medical care costs, and costs of associated supportive services.

The alternative to this is to allow the current national disaster of untreated senior citizens to continue or to provide a program for medical care at cheaper and less adequate levels.

STATEMENT OF DAPHNE H. KRAUSE—Continued

Mrs. KRAUSE. Mr. Chairman, as you will notice by the testimony, the staff was shocked at the kind of people entering our clinic, people who they never dreamed would be in the position of not being able to afford adequate medical care, such as: A former bank employee, a university professor, the former president of an insurance company, several widows of doctors, a Blue Cross claims handler, a grocerystore proprietor, former nurses, schoolteachers, dentists, salesmanagers, truck drivers, concert pianist, barbers, and the widow of a former speaker of the house for our State, to give you some examples.

COMPOSITE PROFILE OF TYPICAL PATIENTS

A composite profile might be that the majority were between the ages of 68 and 72 and in this order: Females, widows, males, widowers, couples, and single people. Most had some relatives in the immediate area; 95 percent lived alone.

Because of the eligibility requirements, their incomes were all below $4,500 for a single person and $5,500 for a couple. The majority had assets below $2,000.

Most owned their own homes, had become "house poor" because of prohibitive taxes, but don't want to leave their neighborhoods. However, because of severe financial problems, there is a growing trend to trade in their house and rent an apartment.

To give you an idea of how they feel, Mrs. Blanche McIntosh told me of a senior who was desperately hungry, but she told me, "don't give her money—take her food or she'll put the money on her taxes because she wants to stay in her own home."

Eighty-five to 90 percent of the patients registering believed they needed immediate medical attention. Many had gone without for long

periods of time because of their fear of bills. They had what I call "paper doctors"; that is, a doctor of record who they didn't see unless they were in a crisis situation.

I remember one woman telling me that her husband had had two major heart surgeries, 10 years ago, and that the costs above Medicare had drained their savings, and at the time of his surgery, her husband had received a prescription for some kind of heart medication which he was still taking, even though he had not seen a doctor for 10 years because of their fear of incurring bills they could not pay.

So many of the seniors told us they didn't know what Medicare covered; that many times they had sent claims in that were rejected leaving them with large bills to pay and very disillusioned as they had thought Medicare was supposed to cover around 80 percent of the costs. In reality, if you included all the things Medicare wouldn't pay for, it was nearer 40 percent of the seniors' health bills that Medicare covered. The seniors felt that the initial deductibles, if you didn't have the money, was an insurmountable barrier even for those who had a little savings left after a lifetime of work.

Savings Drain Away

Seniors have painfully seen their savings drain away with inflation and medical costs not covered by Medicare, and of course the elderly have no way of replacing those savings. The seniors worry about other crisis needs.

They are reluctant to owe money, they think this is dishonest, so they cut out entertainment first, then cut on their clothing, and personal needs such as deodorant and hairdos. They save a dress or suit for "best" to preserve a front and they cut out their health needs doctoring themselves with over-the-counter drugs.

These people don't want to be a burden on society and have a great horror of accepting any welfare.

I would like to read you a case, I hope you will bear with me, because it has a relationship to that board. This is from a woman turned 65 and she says:

I was looking forward to getting on Medicare and don't misunderstand me. I am grateful for it but I have had so very unpleasant dealings with it and I would like to reiterate one instance in particular.

Because of the family history of cancer and my nurse's training, I knew the importance of being watchful for the first signs of cancer. Because of this reason, for 12 years I made annual appointments at the cancer detection unit of the University of Minnesota Hospital.

In 1970, I found a lump on my breast and this led to a radical breast amputation. I also had a history of skin lesions that could become cancerous at any time.

I was particularly alarmed by blood in my stool and pains in my abdomen. Because of this, I requested an appointment at the cancer detection unit. Up to this time, all of my appointments had cost me $25 and I paid these at the time of the appointments, but at this appointment, an expense of $69 was added to the cost, although I did not notice any difference whatsoever in the exam.

A woman I sat next to in the lobby told me her husband had a complete examination and it did not cost him any extra. The university center advised me in a letter: "That we have been assured of favorable consideration from Medicare and will be pleased to accept assignments from patients who have part B, Medicare."

The center then sent the bill to Medicare and the claim was rejected. This whole process took quite a while; in fact, it was a little over a year. I was not clear what the rejection was for or why it had occurred.

We hear that again and again.

I found out later that this was deemed "A routine examination, with no symptoms present, according to Medicare."

This, in spite of the fact that the day of the appointment, along with blood in my stool and stomach pains, I was experiencing heart palpitations and abnormalities were found in my EKG tests. At this time, I did not know what to do or, in fact, if any action at all was required for my part.

I did not feel it was justified for the center to add the expenses, specially when no one explained them to me. The next thing that happened was that the statements came to my home. These statements were very demeaning and played on my sense of dignity. One depicted a picture of an old man with whiskers on the floor and it came with a statement, "Sorry, Medicare refused to help." [1]

There it is, Senator.

Another one was stamped, "Honesty is the best policy." [1] They only added to my frustration.

Just prior to coming to the Abbott/M.A.O. Clinic, the whole matter was sent to a bill-collection agency and service charges were then added to the initial bill. I thought the entire affair was a cheap way of doing things and especially for a party in the medical profession. I have since quit going to the center. If I had known what would have happened, I would never have gone for another appointment.

I then started to take care of myself. The problem persisted and then I was staying on a bland diet and the symptoms slowly disappeared. I wanted to go to a new doctor but I knew that he would go through the same testing that I had previously, again leading to spending more money.

It seemed I would have to accept this. There was nothing for me to do.

After, of course, she heard of us and one of our counselors, I am glad to say, was able to intervene on her behalf and get those payments made by Medicare but what a disgraceful thing to send the senior citizens of this country—a picture of an old man—well, I do not know. It is just disgraceful.

I get so angry when some people talk of cleanliness being close to Godliness. You have a choice between cleanliness and food, guess what you choose? But their pride in their personal appearance is such that they always save that best dress, that best suit. They cut out on their health needs, they doctor themselves with over-the-counter drugs.

One of our biggest problems is to counsel with them that nothing we are giving them is charity. They paid the taxes of this country during their working years.

Mr. Chairman, before I do go on, I would like to insert some 84 pathology reports and medical histories. I would like to discuss with you some of the things that are in them.[2]

I remember—there are such things as an aneurysm, a World War I volunteer who had never seen a doctor since that first visit, a man who had a heart attack 5 days before coming to the center. But let me tell you what I did, Mr. Chairman—I do not know if you are like me, some of these medical terminologies, I am not sure what they mean—so we went to these records and each case history and I had professional medical people write down a brief history description.

Last night, when I was sitting in my room, I was trying to think how it was possible, when we all sat here to read these statements, to get across to you what a truly dreadful thing it is these people are not getting health care.

These are not just people coming in with a few arthritic pains or needing some kind of arch support and maybe if I just come in and

[1] See exhibit, p. 1250.
[2] Retained in committee files.

read these statements, just a few of them, you will get some feeling of the horror we felt in discovering a situation.

This case, the man—no, it is a woman. She has a bladder coming down through her vagina, low back pain. This had to be repaired. She had a heart problem during the surgery. This client is 73.

Another woman, her bladder is protruding through her vagina, upper abdominal pain. Large mass in the abdomen. It was aneurysm, so she had a hysterectomy and she had to have this large aneurysm removed.

Ongoing arthritis. This person is 93; has a history of heart disease, increasing short dizzy spells, hyptertension, a heart attack, is now on medicine which she did not have before to stabilize the heart condition, to make life a little more endurable.

This person is 81, hypertension, low back pain, has heart disease which should be evaluated, probably coronary arterial disease.

Kidney infection. This one is a diabetic, age 70, acute perforation of the bowels, recurring cancer of the abdomen, recurrent obstructions, lesions left from his past surgery 18 months ago which was not repaired.

This is a client who is 74, anemia, back trouble, enlarged liver, and arthritis. This one had fractures some days before that she did not even know that she had after she was discharged from a nursing home. These fractures were then discovered that happened in the nursing home.

This one had difficulty for many years with having high blood pressure.

This one with a hernia. This is a very common problem, apparently, an elderly woman, and it makes their life unendurable if it is not repaired.

This one has a pacemaker and this is the first to be put in, also diabetic, also high blood pressure.

Again, hypertension. We hear that over and over again; he also has a heart disease, the artery was blocked.

This must be one of the ones that was stricken. Another had hypertension, thyroid function does not work.

Cardiac arrest.

This lady has cancer on the right breast, heart disease.

This one had a cancer in the rectal region that was so large, it went into the vagina.

I am wondering, Senator, if you want to hear any more?

Senator MUSKIE. I think we want to be sure to get the rest of the story, Mrs. Krause.

Mrs. KRAUSE. I just wanted to make the point because it is very important, because later on you will hear that people have said these people were just coming in for little checkups.

Senator MUSKIE. I say that the story is coming through very clearly this morning. This is excellent testimony. We will be delighted to receive these.

You say 86 individual files for the record?

Mrs. KRAUSE. Senator, there are several thousand back in the clinic.

Senator MUSKIE. I understand that this is just a sample and we are delighted to have them.[1]

Mrs. KRAUSE. I would now like to introduce the people who can tell us the story better than I can. Dr. Thomas Werges is a diplomate of the American Board of Internal Medicine.

STATEMENT OF THOMAS WERGES, M.D., DIPLOMATE, AMERICAN BOARD OF INTERNAL MEDICINE

Dr. WERGES. My name is Dr. Thomas M. Werges. I am a graduate of the University of Minnesota Medical School, class of 1968. I am a diplomate of the American Board of Internal Medicine, and I am a member of the American College of Physicians. I am licensed to practice medicine in the States of Minnesota and California.

First, I would like to discuss my clinical experiences at the Abbott-Northwestern Hospital, Inc./M.A.O. Senior Citizens Clinic. I was surprised at the remarkable degree of serious illness exhibited by at least 50 percent of the patients. Although one would expect to see a number of serious illnesses in patients in the 65 and over age group, a good number of these patients have not been seen by a physician from periods ranging from 1 to over 50 years.

There were several reasons given by the patients when I asked them regarding their lack of continuity of health care. The first and most basic reason was simply their inability to pay. Most of the patients in our clinic live entirely on their Social Security check which makes it extremely difficult to pay for medical care which is not covered by Medicare. Also, to a lesser extent, a number of the patients expressed a lack of knowledge about obtaining entry into the health care system. Although my experience in practice is somewhat limited, I was astounded that there was such a large volume of patients with significant and serious illness who are unable to afford medical care. Of the various types of diseases which are seen in our senior citizens clinic, by far the most common is vascular disease which includes heart disease, stroke, and their predecessor—hypertension. In addition, cancer, arthritis, emphysema, and general malnutrition are also frequent findings. The complex nature of handling these illnesses in the elderly patient became readily apparent when I joined the senior citizens clinic.

When the senior citizens clinic began expanding, we were inundated with a large number of extremely ill patients who required careful medical attention. Personally, I am still amazed by the degree to which I have underestimated the need for proper medical care in the elderly, and I believe the fact of our senior citizens clinic aptly demonstrates this point.

The incredible number of patients that needed treatment for serious chronic debilitating illnesses which have previously gone untreated because of lack of physician contact, simply because they are unable to afford medical care, is probably the most significant point I can

[1] Retained in committee files.

make. I cannot stress too strongly my own feelings in this situation. I think for most of us who are still relatively young and healthy, it is extremely difficult to understand what chronic pain, what chronic disability, what chronic disease can do to a patient in any age group, but particularly to the elderly patient. And then to compound the problem by making it essentially impossible for elderly people who live on Social Security income, to obtain medical treatment to alleviate to some extent the degree of disability and suffering, is inexcusable.

If our clinic population is truly representative of the national population of the elderly, and I believe it is, the total number of patients in this country who suffer with their diseases untreated because they cannot afford medical care must be staggering.

Visual Problems Common Among Elderly

Now, I would like to mention a few specific areas of disability which are not life-threatening illnesses, per se, but are very important to the well-being of the patient. As we are all familiar, the human being is primarily a visually oriented animal. In the geriatric population, the incidence of visual impairment is significant, and after discussing with many of my patients who do have visual handicaps why they have not had these attended to, the recurring theme is inability to afford treatment. Through our senior citizens clinic, we have referred a large number of elderly patients whose visual impairment has been significant to a consultant ophthalmologist for treatment. With improved vision, they find many of their other disabilities easier to bear because they now can read, sew, knit, or engage in a number of other visually oriented activities. Hearing impairment in the elderly is also a significant problem. I am extremely sensitive to this point because I know a number of hearing-impaired people who I have met through my wife's parents who are themselves hearing impaired. This is a very great disability, not only in communication with friends and relatives, but also in the very important area of physician-patient communication, particularly in relation to the instructions they are to follow and the medication they are to take.

Although hearing aids are not a panacea for the hearing impaired in the elderly population, they can be a considerable help when used in appropriate circumstances. Again, the problem is money. Hearing aids are expensive and many of the elderly simply cannot afford the expense.

My next point relates to the dental problems in the elderly patient. Because of their age and lack of previous dental care, many of these patients have significant dental problems. Because of this, they eliminate many foods from their diet necessary for proper nutrition. Once again, the problem is the expensive nature of their dental repairs, none of which are covered by Medicare.

My final point in this area relates to total hip replacement in the elderly patient with severe arthritis. It is truly remarkable to see the transformation of a bedridden patient into an active independent person after total hip replacement. Again, the expensive nature of the surgery makes it unobtainable because of the significant difference between what Medicare pays and the total cost of surgery and hospitalization to the patient.

I would now like to discuss geriatric pharmacology. Because of the multiple health problems in the geriatric population, most of them take medication. As we all know, the introduction of chemicals into the body is a two-edged sword. The beneficial effect and the adverse side effects must both be considered. The incidence of adverse side effects increases rapidly as we increase the number of medications a patient is taking. The side effects of individual drugs have been relatively well documented. However, the interaction between medications in the patient is not yet well understood and a good deal of research remains to be done in this area.

Doctor-Patient Communication Gap

After talking with most of my patients about their medications, I asked them specifically when they took them and for what. I was absolutely amazed to find that many of the medications are taken only on an intermittent basis and not according to instructions and sometimes the medications are taken for the wrong purpose. The reason for this is a communication breakdown between the patient and the physician which is fostered in part by only episodic care. The reason for this is that Medicare pays only for visits at specific intervals and if there is an illness or medication requiring more frequent visits the patient then must pay for these visits himself.

An excellent example of communication breakdown would be a patient that I was taking care of who had serious heart disease. He was taking both digitalis and quinidine, both of which are extremely potent drugs. He put both of his medications in the same bottle, and in the resulting confusion, received too much digitalis and became quite sick as a result of this. The point that I am making here is that patient-physician communication is extremely important and when this communication breaks down, the patient is likely to have untoward effects as a result of this.

Part of the process in maintaining communication between patient and physician are return office visits at whatever interval the physician believes is indicated for reviewal of the patient's programs. If the patient is reluctant to return for followup visits at intervals more frequent than what Medicare is willing to cover, the lack of proper medical followup can certainly lead to breakdown in communication.

Another reason that patients do not take their medications as indicated is the cost. On a visit to our hospital pharmacy, I examined a number of drug costs and all I can say is that I was impressed by the significant cost of medications.

I have talked to several of my geriatric patients who stated they were paying in excess of 25 percent of their monthly income on medications. To reasonably expect them to do this over a long period of time, places a severe financial burden on their ability to care for themselves in an independent situation.

I would now like to direct my attention to the Federal approach on health care in the elderly patient, specifically Medicare. Medicare encourages only episodic—crisis intervention—medical care. This is not only not beneficial for the patient, it is extraordinarily expensive. If we discourage the patient by placing financial barriers to prevent him

from seeking medical aid unless he has a medical crisis, the cost of his medical care will increase dramatically.

I interpret the reasoning behind this point of view as a means to prevent overutilization of the health care system, but it instead encourages underutilization until such time when medical catastrophe occurs and the patient seeks help and, in many instances, is too late to be helped.

Preventive Medicine in Action

The most significant example that I can use here is high blood pressure. Hypertension is one of the most significant public health problems in this country today, not only in just the geriatric age group. By waiting until target organ damage has occurred, such as stroke or heart attack, is simply disastrous. The early detection and treatment of hypertension significantly reduces the mortality and the morbidity from vascular disease. And as an additional benefit it reduces the cost of health care.

The detection and treatment of hypertension is an excellent example of preventive medicine in action. This is why I strongly believe that Medicare of any national form of health insurance plan should emphasize to a large degree preventive medicine rather than episodic crisis intervention.

Another thing that I have discovered to my surprise was that Medicare does not cover 80 percent of the patient's medical expenses. In fact, in my experience, Medicare covers only 40 percent of the patient's medical expenses. For patients living on Social Security, this might as well be nothing since the inability to afford 60 percent of their health care effectively eliminates them from seeking treatment. This has been a significant point in the M.A.O. Senior Citizens Clinic, in that we cover the medical expenses that Medicare does not. This has allowed a large number of patients who have not been receiving medical care finally to avail themselves of proper medical attention. And by proper medical care, I mean not only crisis intervention, when necessary, but also preventive medicine.

Because of this approach, Medicare indirectly pressured the physician to tailor his evaluation according to what Medicare is likely to pay for. Particularly, if he realizes that his patient simply does not have the financial ability to pay for these tests that Medicare is not likely to cover. This is extremely unfair to put this type of pressure on a physician who when unencumbered by the consideration of economic necessity for his patient might choose a more thorough and complete evaluation in the interest of his patient's health needs.

I would now like to discuss the integrated health care system that the senior citizens health clinic provides for the elderly patient. This is a comprehensive program of medi-supportive services sponsored by the M.A.O. center: (1) home delivered meals program; (2) employment services; (3) homemaker services; (4) handyman services; (5) transportation services; (6) legal services; and (7) counseling services.

These medi-supportive services provide a truly integrated approach to health care in the elderly. They make the physician's job of providing health care much more productive than it might ordinarily other-

wise be. It also allows the physician a considerable range in the selection of options for care of his patient.

In addition to the previously mentioned services, I have also been involved in a relatively new concept which we have beginning at our clinic, that of the nurse practitioner. For the past several months, I have been involved with a nurse practitioner and part of her training. She works with me on a day-to-day basis in the clinic, seeing and evaluating patients and spending a considerable amount of time with the patients that I might not otherwise have had available, in discussing with them their medications, proper dose schedules, dietary needs and in general helping me to provide balanced essential medical care.

Thus, in the M.A.O. Senior Citizens Clinic, the physician works in conjunction with a large number of professionals, who together, provide an integrated total health care system for the elderly.

My final area of discussion will relate to physicians and the care of patients in our M.A.O. clinic. With the expansion of our clinic, the influx of such a large number of patients and the shortage of physicians has been a truly significant problem. Nationally, there is considerable debate as to whether a true shortage of physicians actually exists or whether this is a distribution problem. I am not here to debate that point, but I can say that in my experience with our senior citizens clinic, we do need more primary care physicians. And by primary care physicians I mean family practitioners and internists to work with us and provide medical care for the elderly. There have been suggestions of specifically establishing residency programs designed solely for the treatment and care of the geriatric age group. Personally, I think these ends could be well accomplished by a specific emphasis in internal medicine and in family practice training programs covering the complicated and difficult health problems of our elderly population so that when these physicians come out to practice, they will be fully equipped to deal with this rapidly enlarging segment of our population.

Thank you.

Senator MUSKIE. Thank you, Dr. Werges.

I wonder if we might interrupt for Senator Mondale who wanted to have a few minutes for some questions and since this is a panel of witnesses largely from his State, dealing with a program which is intensely interesting, I think we ought to grant that courtesy, so I yield to Senator Mondale.

STATEMENT BY SENATOR WALTER F. MONDALE

Senator MONDALE. Thank you, Senator Muskie, for your generosity.

I am proud of the fact that this experiment occurred in Minnesota. I am told by the staff there is nothing like it in the country.

I commend Abbott-Northwestern staff for doing so and Daphne Krause for her remarkable organization for the work they have done and for the absolutely compelling case you have displayed, which I think clearly demonstrates the inadequacy of the present payment system, the delivery system, the mammoth and heartbreaking need not being met and it helps flag some of the profound problems we have as we commence work on some sort of national health insurance program.

I am on both the Health Subcommittee of the Labor and Finance Committees and one of the key issues is deductibles and coinsurance.

The argument is always made that we have to have a high deductible, otherwise people come in with phony health problems and waste the time of the doctors and the hospitals, et cetera; but here, we see the other side, that where deductibles apparently are keeping thousands of very ill senior citizens away from health care that is essential to their own survival in health.

They are not minor problems but very profound problems and I think the case you make is an absolutely overwhelming one. I am very proud of the work you are doing.

As I understand it, Abbott-Northwestern took the very unique position that they were going to provide health care for senior citizens, eligible for medical care, and not charge them deductibles, not charge them in excess of the medical schedules, and it would not require payments from coinsurance. Is that correct?

Mr. ADAMOVICH. That is correct.

Senator MONDALE. The result was literally thousands of senior citizens who came to Abbott-Northwestern for treatment of their health problems received that treatment.

The other thing is that by reducing the rates and by opening up their admissions to all comers without the previous medical examination or health test, you did that, is that correct?

Mr. ADAMOVICH. Yes; the drop in the rates of the policies came about at the time the clinic opened. We cannot say that was the sole related matter but as far as we know, it is the first time that such an occurrence happened in terms of reducing rates.

Senator MONDALE. I have not heard of any insurance company reducing premiums and increasing coverage, have you?

Mrs. KRAUSE. If I may, may I make Senator Mondale aware of some very interesting minutes that were taken by Mr. Kramer.

Senator MONDALE. I read those and I will get to that in just a minute. I think this points up a problem.

When Medicare was adopted and then implemented, I wanted very much to get Blue Cross established as the intermediary in Minnesota. They asked me to do that, and I worked very hard, over some resistance, in order to get them designated, and they were; and I guess we are going to hear from the "Blues" tomorrow.

I gather from the doctors, they are testifying that they were taking care of real health needs. These senior citizens would come in, they would examine them, they would identify serious problems and they would do what a competent doctor must do after tests and the other necessary evaluations had taken place in order to give a responsible amount of treatment?

Mrs. KRAUSE. Yes.

Senator MONDALE. I am going to get to the point. The response of the intermediary was that these were initial screening exams uncovered by Medicare. That is their argument.

Mrs. KRAUSE. That is what they say, but in the beginning, when I was talking to George Adamovich, he insisted on having a physical for each of the seniors, because he felt that was quality health care. I told him that I felt it was unnecessary, because I felt the problems were gross.

Now, right from the beginning, they knew and still have absorbed $25,000 for those particular physicals. The charges which are under dispute are not those physicals. Abbott is not attempting to get reimbursement for those.

Another interesting thing is that I had my staff research claims made prior to our opening the expanded clinic in 1973 and we have some examples here.

Perhaps this one could be taken up to you that show that diagnostics, this is their own form, says M.A.O. diagnostical services—they called them that.

Senator MONDALE. How long have you been the administrator, Mr. Adamovich?

Mr. ADAMOVICH. Since January 1970. I have been at the hospital for approximately 16 years, one way or another.

Senator MONDALE. I see. Is it your impression, that is, just following the commencement of—this opening of the clinic, that Medicare began rejecting this kind of claim?

Mr. ADAMOVICH. Yes; if I could comment on this, in perhaps three parts.

First of all, as you know, we in the health care field in Minnesota viewed Blue Cross of Minnesota as being much more progressive than other plans across the country, so I would like to make that point.

MEDICARE TERMINOLOGY CAUSE REJECTIONS

I think in the area of reimbursement of the Medicare claims. specifically, we have really got two problems: One has to do with the issue of how the act is written in the first place, what is excluded which causes this large loophole.

Second, Social Security Administration, or whoever drafts the regulations, also has to bear part of the responsibility for writing them in such a complex way that they are subject to misinterpretation.

And third, I would guess that what we have done is to create a very large demand on dollars in that State, and, also, you know processing of claims by individuals so that all of these things combined are involved.

Senator MONDALE. As I understand, under the Medicare law, you have sort of a vague standard. If I come in and say, I would like a medical checkup. a screening examination, then that is not covered?

Mr. ADAMOVICH. That is right.

Senator MONDALE. But if I come in and say, I am sick and the doctor looks at you and says we have got to have some tests here to determine how precisely we should treat you, that is covered?

It just depends. so it can become a fact question of the conduct: Is it an examination or is it a part of a diagnostic work of a doctor treating the patient?

Mr. ADAMOVICH. To illustrate your point, I think it would be true that many of our staff in completing these forms, especially in the early days, were very straightforward in what they wrote down and got large numbers of rejections related to language.

I think it is an indictment of our system in that it takes a course in special language and game playing in order to get the right informa-

tion on the form in order to get reimbursement. This is not the way to run the system.

Senator MONDALE. That is correct. Is not this a further problem, that if a claim is approved, it is in this case paid for by Blue Cross?

Mr. ADAMOVICH. Yes.

Senator MONDALE. And the intermediary that determines whether the claim is compensable—covered by the insurance—is also Blue Cross?

Mr. ADAMOVICH. That is true.

Senator MONDALE. And if someone with Blue Cross insurance feels that he or she is entitled to coverage and objects to a denial of coverage, they appeal to the intermediary, which is Blue Cross?

Mr. ADAMOVICH. That is true.

Senator MONDALE. Is that correct?

Mr. ADAMOVICH. So far as we know, that is correct.

Senator MONDALE. Is not there a conflict of interest?

Mrs. KRAUSE. Senator, let me point out something strange. There is a request for a Medicare payment, a normal request, and there is a place there that says, "Do you have any other insurance, and if so, will you name it?"

Now, is it not rather awkward if you see your own insurance company named on a policy and you are trying to decide whether you should pay it or make Medicare pay it? See what I am saying?

Senator MONDALE. That is my point, of course, that the intermediary under the law, as I understand it, determines whether a service cost is covered under Medicare.

CONFLICT OF INTEREST?

In this case, the insurance company that provides those proceeds, if they are covered, is the same company that is the intermediary?

Mr. ADAMOVICH. Correct.

Senator MONDALE. So that they wear two hats and maybe—I think we do have a progressive Blue Cross in Minnesota—I expect that, but it puts them in an impossible position of, even when they rule correctly, of a conflict.

It also creates an incentive, it seems to me, to help Blue Cross in terms of its financial problems, to come in, in the form of a governmental intermediary, quasi-government, say, that is not covered under Medicare, and then put a big stamp on the bill and say, "Sorry, Medicare refused to help." So I wonder whether we do not have a conflict here.

Mr. ADAMOVICH. I agree we do on that principle, and there is another area that is critical, and that is in the area of quality of care; this kind of system, as has been true in the welfare system, provides that what is given to the patient in terms of test or treatment is what you pay for and, therefore, the same person making a payment is also, by that definition, the determiner of quality of care.

I want to make that point because I think in any kind of intermediary situation for national health insurance, we should certainly avoid putting the quality-of-care issue in the hands of the same agency as is paying the bill, because we will tend to sink to the lowest level; that

is, as money is less available, the quality will follow on that kind of payment plan.

Senator MONDALE. Now, I am told by counsel here that an uncompensated insurer—that is, one of the senior citizens who is not covered—finally appeals to an intermediator so that if the intermediator says, "No," that is the end of it. It seems to me we have a fundamental problem here.

Senator MUSKIE. Could I put it in this way: If the Blue Cross of Minnesota acted inappropriately or improperly, that would constitute discrimination?

Mr. ADAMOVICH. Yes.

Senator MUSKIE. Now, if that is the case, then what is involved is the intermediary concept, which Senator Mondale has identified, but if in fact, one judges that they did not discriminate, they were really acting in accordance with the law or the regulations, then the problem is with the law or the regulations, is that not true?

Mr. ADAMOVICH. Yes.

DIAGNOSTIC SCREENING

Senator MUSKIE. Well, now, to help us make the choice of interpretations of what is involved here, in your prepared statement, you discussed diagnostic screening?

Mr. ADAMOVICH. Yes.

Senator MUSKIE. Diagnostic screening should be reimbursable, according to the law, should it not?

Mr. ADAMOVICH. Absolutely.

Senator MUSKIE. And it is not now, in connection with your program, which you have been describing this morning. Is that the case?

Mr. ADAMOVICH. That is true.

Senator MUSKIE. How does the present interpretation compare with the interpretation before this expanded program was initiated?

Mrs. KRAUSE. Well, we handled the Medicare for the senior citizens' expanded program, the filling out the forms, and we—and as it was said, you have to watch the language and we did not have any problem then.

Senator MUSKIE. So the problem has arisen since your program was expanded?

Mrs. KRAUSE. That is correct.

Senator MUSKIE. This fact, too, is a part of the problem. Is that not so?

Mr. ADAMOVICH. That is correct.

Mrs. KRAUSE. It makes you wonder.

Senator MONDALE. We will check with the Finance Committee staff which deals with this; we checked with them yesterday, and they say that clearly Medicare was designed to cover people who were sick and the diagnosis tests, that are a part of that, and the distinction was that routine screening of people may be perfectly healthy on a routine basis, that is what was not intended to be covered. Maybe it should be.

It sounds to me it ought to be, but in every instance we heard of, we have a person very ill here.

Mrs. KRAUSE. That is right. That is why I said to Mr. Adamovich in the beginning. I did not think he should pay for that $25,000

worth of debt. I felt it was unnecessary, but the incredible thing, the hospital still has to pay for that, which they should not, and yet we are being turned down on these tests for these very ill people. It does not make sense.

Senator MONDALE. Thank you, Senator. I must leave but it does seem to me we have got a basic problem here.

Senator MUSKIE. It seems to me that, at best, it puts them in a very ambiguous position, but in any case, are you under the impression that the Blue Cross is hostile to your expanded program?

Mrs. KRAUSE. Not personally. I felt in the minutes which I read, that it was a very unfortunate choice of words used in saying that these people would not have had care, but I chose to say—she probably said it because she was irritated and overworked or something like that; but yet, I cannot get away from the fact that prior to the expansion we did not have any problems.

Now, after the expansion, we are having all of these rejects. We are treating the same kinds of things as before as we are now. There is no difference in our medical treatment.

It is a fact that there are many more people, many of them even sicker than the others because of not having had care but it just does not make sense to me.

Senator MONDALE. Thank you very much.

Senator MUSKIE. Thank you, Senator Mondale.

Mrs. Krause, we have about 20 more minutes. How can we best use that 20 minutes?

Mrs. KRAUSE. Well, we do have another doctor here that you might want to listen to.

Senator MUSKIE. Fine.

Mrs. KRAUSE. And then if I may just finish briefly by telling something that I do think is important in terms of finances.

Senator MUSKIE. We will hear from the doctor and then conclude and, as I said earlier, all of your testimony is in the record.

I must say that we have had excellent attendance of Senators here this morning, reflecting their very considerable interest in your experiences and you can be sure the written record will be read as far as your testimony has been elicited this morning.

Our next witness is Dr. Carlos P. Sullivan.

STATEMENT OF CARLOS P. SULLIVAN, JR., M.D., NEUROLOGY RESIDENT, UNIVERSITY OF MINNESOTA

Dr. SULLIVAN. I am Carlos P. Sullivan, Jr., M.D. I received my degree from the University of Washington and served my internship at Hennepin County General Hospital, Minneapolis. After serving 1 year as a resident internist at Hennepin County General Hospital, I served 2 years in internal medicine in the U.S. Navy at Parris Island. Upon discharge, I became a neurology resident at the University of Minnesota and will complete my 3-year residency on June 30, 1974, after which I will enter practice at Eureka, Calif.

During the year as a resident physician at Hennepin County General Hospital, I was involved in organizing and implementing a program

providing continued care for those county patients discharged from General to rest homes. This involved the indigent and poverty-stricken patients. While at General, I had marked difficulty with the social services at my disposal for patients who could have otherwise returned to their homes. It was not uncommon to retain patients in the hospital for extended periods until they gained full facility to care for themselves. Had supportive services, of the nature which I have found at the Minneapolis Age and Opportunity Center been available, many patients could have been discharged earlier, which is better for the patient, considerable savings to the taxpayer, and allows the physician to give his attention to more urgent medical matters.

For the past 3 years I have been on the house staff at Abbott Hospital at Minneapolis. During the first 2½ years, I came in contact with M.A.O. patients only when they were brought to Abbott in an emergency situation at night. My service was limited to examination and contact with the M.A.O. physician.

Physicians Recruited

However, in November 1973, my attention was focused on M.A.O. and the enormous number of patients having a multiplicity of medical problems requiring immediate medical attention. Dr. Bonewell of the M.A.O. clinic contacted me and discussed his problem in meeting this grave need and the concern of Abbott Hospital and M.A.O. in being able to render them the same quality health care experienced by any patient of the hospital. I set out to help recruit a number of the young doctors in the community. All in all, we recruited about 15 of them to work with the clinic on a part-time basis. They accepted assignment on the basis that they would be given assurance that the laboratory workups, consultation referral, and hospital care would all be available. They were assured that this was available at Abbott Hospital through the M.A.O. program.

We had first anticipated 200 to 300 patients—this estimate was soon raised to 2,000—very rapidly raised to 3,000, and is continually rising.

Of the typical patient seen, a minimum of 1 hour of physician's time is required to deliver the proper medical evaluation, a significant amount of which involved either immediate hospitalization, diagnostic evaluation by consultants and/or laboratory studies. I saw no patient who did not have a medical problem requiring attention. Many of them had learned to live with their illnesses. When examined, they were found to have multiple medical problems, many of which, if not managed promptly and properly, could only lead to early confinement. Examples of these are congestive heart failure, chronic obstructive lung disease, coronary artery disease, cancer, hypertension, and renal disease, to name only a few. One patient had been experiencing episodic chest pain for about 2 years. He had seen a doctor who had found no explanation for his problem. He experienced a particularly severe episode and through M.A.O. was brought to the emergency room at Abbott. With the excellent facilities available, it was found that he had a weakening and widening of his main artery, the aorta, leading from the heart. Fortunately, he was able to be treated at this time, but he had been walking on a tightrope for 2 years. In all likelihood,

in a county hospital, he would have been treated for his pain as his original physician had been doing.

In the M.A.O. system it is possible to arrange a definite appointment schedule so that the patient does not have to wait for an endless time before being examined. This is only possible through the coordination of the M.A.O. staff in the areas of transportation and facilitation. This is most important in the treatment of these patients.

It is particularly comforting for a doctor to know that when a patient is discharged that there has been coordination with his family and with others which will assure continued surveillance. For those who are being returned to their residence, the availablility of the entire spectrum of M.A.O. services allows the physician to release patients.

The spectacle of so many people who actually needed attention who were unable, sadly, because they did not have enough income to afford that attention, but who had not and were not about to, become reduced to the welfare level, is something which I shall never forget in my future practice. I recall a patient who had been prescribed an anticoagulant, a very dangerous drug requiring frequent surveillance—in the nature of every 4 to 6 weeks—who had received no surveillance for 12 years because he said he was not able to afford doctor fees.

There were patients whose problems were not as spectacular as others, who through M.A.O. and the clinic, and with proper evaluation and treatment, have had their years of remaining life made immensely more comfortable and enjoyable. The debilitating effect of some diseases makes life "not worth it" and unless the opportunity is given to these sufferers to have the cause determined and the necessary prescriptions available at a reasonable cost, they will lead miserable lives. I am only sorry that a means has not been found to provide, within their means, necessities such as glasses, dental care, and proper hearing aids, as is the case with many welfare patients.

Total High Quality Care Required

I cannot overemphasize the requirement for total care of high quality for the elderly people. Their multiplicity of complaints requires an exceedingly thorough laboratory workup, a careful physical examination, an understanding and dedicated hospital staff, the coordination by a trained and skillful counselor, and the multitudes of services furnished by the M.A.O. organization.

Just recently, a 93-year-old lady under the M.A.O. program was treated for a duodenal ulcer, she had been a Minnesota Mother of the Year. Her family was most concerned as to her welfare upon discharge and discussed this problem with me at length. I was able to outline to them, much to their satisfaction and gratitude, that she could go on living in her own home through the supportive services of the Minneapolis Age and Opportunity Center.

STATEMENT OF DAPHNE H. KRAUSE—Continued

Mrs. Krause. Mr. Chairman, I would like to enter into the record 72 samples of medical records showing the kind of pathology these wit-

nesses have been discussing. There are thousands more in the records department of the clinic.[1]

Mr. Chairman, during the intake of the expanded clinic, my staff and I were approached by many senior citizens who had supplementary insurance policies which I have referred to as "medi-gap" policies asking us whether they could now drop them. As one man told me, "I want to drop my policy because that $11 will buy me three of four more meals a month."

A woman told me that she wanted to drop it so she also could buy more food. Her 90-year-old husband had become so weak because of their insufficient diet, that he had taken to his bed.

We advised the seniors to check their policies closely in case anything was covered that we had not. Otherwise, we certainly hoped they would drop policies that ate up the money they needed for the necessities of life, with so little return to the senior in terms of coverage. We later learned a number of the seniors had dropped their medi-gap policies.

In our State, Blue Cross and Blue Shield and Travelers Insurance are the intermediaries for Medicare.

An interesting development took place on January 24, 1974. An item appeared in the Minneapolis Star headlined "Elderly Will Get Break on Rates, Blue Cross and Blue Shield Say."

The article which I will introduce into the record, Mr. Chairman, goes on to state that reductions will be in effect for some 70,000 people after March, and that for the first time there is an open season for obtaining this insurance. No health history will be required. It is also stated that the seniors will receive more benefits.[2]

I understand this is the first time in the history of this particular insurance, that they have dropped rates, increased benefits with the additional come-on that no health history will be required. All this within less than 3 months of our subsidized clinic opening, and to our knowledge, that many seniors were dropping or had dropped their Blue Cross policies. Certainly, there may be no connection, but if so, it is a very interesting coincidence.

Medicare Rejects Increase

About this time I also became aware that the clinic was receiving an unusually high number of rejects from Medicare, for whom the same Blue Cross is the intermediary.

I was told by Mr. Adamovich that the majority of rejects were based on the tests being ordered by the physicians and that Blue Cross was classifying them as tests ordered for "physical checkups or screening," because of their pattern which produced a number of similar charges.

I was told that the hospital staff had met with staff from Medicare on April 11, 1974, to discuss this situation, and at that time it was clearly pointed out that the hospital knowingly assumed the burden of the cost of the physical as set up in phase I. Even though the pathology that was discovered clearly showed these tests were needed, this sum amounted to some $25,000.

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[1] Retained in committee files.
[2] See appendix, item 6, exhibit I, p. 1323.

In addition, the hospital was and is accepting the burden of the cost of a number of tests which are not covered by Medicare, although they should be, such as Pap smears.

It was pointed out to Blue Cross at this meeting that any tests ordered since the clinic has discontinued the so-called physicals, were ordered because of the physicians' concern that these tests were a necessity. It was also pointed out that the hospital realized with a large influx of patients and the many doctors and nurses handling records, that there was no doubt that their billing to Medicare may not always have complied with the extremely complex system set up for reimbursement.

In my own opinion, the way the Medicare law was written, it almost seems that these loopholes are created for the patient to fall through. In this case, the hospital was hurt, but M.A.O. has numerous examples where if the doctors do not accept assignments, the patient suffers the consequences.

The fact remains that even providing for all the gray areas these rejects fall into, there is the significant fact that prior to November 1, 1973, the Abbott-Northwestern/M.A.O. Clinic rarely had a reject and had no occasion but to think that Blue Cross and Travelers Insurance were most cooperative, and I'm perfectly sure mistakes were made then in writing up Medicare forms.

Sampling of Claims Accepted, Rejected

In order to demonstrate this to you, Mr. Chairman, I asked medical records at the clinic to come up with some samples that are similar, of claims accepted prior to November 1, 1973, and samples of similar cases that were rejected after we opened the subsidized clinic which I would now like to enter into the record.[1]

As can be plainly seen on examination, there seems to be no reason for these claims being rejected now, if similar cases were accepted, unless the Medicare law has been changed in that area, and I don't believe it has been.

On top of this I asked for and received a copy of the minutes taken by Mr. Richard Kramer at the meeting held April 11, 1974 between the clinic staff and Blue Cross.

Mr. Chairman, I would like to enter these minutes into the record, together with affidavits from Richard Kramer, Raymond Daum, Lavetta Pearson, Wayne Abell, Dr. George Bonewell, and Helen Yates, who were present at the meeting.[1]

At this meeting a number of remarks were made that are of peculiar interest and I would like to read some extracts to you. Ms. Blood, who is supervisor of the medical review team of Blue Cross, stated that Blue Cross was stunned by the volume of claims and was finding it difficult to determine which claims should be paid. She stated that "it was almost a flip of the coin."

Ms. Blood indicated that Blue Cross was attempting to pick out acute problems and reimburse these claims. Blue Cross does not feel that they can pay claims for diagnostic screening for chronic problems.

[1] Retained in committee files.

Mrs. Pearson, who is present today, then presented cases where she felt the conditions were acute and the claims were rejected.

Mr. Kramer, referring to rejects on technical points, said the following : He pointed out that the present Medicare claim form does not ask for this kind of information and he inquired if other hospitals were being asked to do this. Ms. Blood stated that this is not a standard procedure, but that Blue Cross was finding it difficult to cope with the volume of M.A.O. claims. Mrs. Kuehn pointed out that this would create a significant expense for the business office and medical records departments.

Dr. Bonewell stated that in his opinion all tests being ordered were very basic for this patient population in 99 percent of the cases.

Mrs. Pearson presented the case of a patient with chronic obstructive lung disease in which the total claim was rejected. Ms. Blood stated that this patient had no reason to see a doctor since he did not come in with acute symptoms. Ms. Blood agreed with Dr. Bonewell that the tests ordered for this patient were related to the patient's symptoms, but she argued that, in her opinion, the patient would not have sought care if the clinic did not exist. Dr. Bonewell stated that if he did not order these tests he would risk a malpractice suit.

Ms. Blood went on to state that "physical exams are verboten" totally ignoring the fact that the hospital was absorbing all of the costs of the initial physicals.

Ms. Blood stated that the clinic has been "singled out because you have opened up your arms and said to everybody, come to us—we will take care of your problems." Ms. Blood added that "Medicare cannot maintain—referring to health maintenance—people in a healthy or unhealthy position." Dr. Bonewell suggested that the clinic was being discriminated against, and Ms. Blood stated that "yes, we are singling you out." Dr. Bonewell stated that, in his opinion, asking the clinic to justify each claim with additional information was discriminatory. Ms. Blood agreed.

At a later point, she further stated we—Blue Cross—are being discriminatory against the clinic because of the "way you are being set up."

Mr. Chairman, one realizes that faced with an unusually large volume of work, some staff tend to get irritated and make remarks which later they regret, and we would hope that this was the instance here. However, these remarks were accompanied by actions which had been taken and continue to be taken which follow the path of Ms. Blood's statements. Possibly we could also say that these rejections were made because of the law being poorly written, ending up in essence deceiving the people it was intended to help.

Whatever the case, Mr. Chairman, I present the facts to the best of my knowledge for you to determine.

Rejections Not Necessarily Final

I have been told by Mr. Adamovich that Blue Cross in our State has been one of the most progressive as compared to other States.

I've also been told that it should be understood that these rejections are not necessarily final in that they will be appealed by the hospital. However, it should also be noted by our own experience, where an attorney has appealed on behalf of our clients with Medicare, that there have been some totally uncomprehensible denials based on technical loopholes.

And finally, Mr. Chairman, in this area, I would like to read you two reports given to me by my staff, which were written, I believe, after Blue Cross had been notified of this hearing. This has greatly disturbed me as being an unnecessary harassment of our client.[1]

Mr. Chairman, I would also like to enter into the record two copies of informational letters M.A.O. has sent to clients which show the difference between appointments for registration, phases, and physicals, and the letters state that if a client becomes ill, they should call for an appointment, so it is understandable that these clients were upset and confused when they were phoned by the women from these insurance companies.[1]

Mr. Chairman, ever since M.A.O.'s inception, I realized that even though we accomplish our objectives of providing alternatives to institutionalization, which the seniors overwhelmingly want, that in order to try and provide an ongoing funding base for this purpose, we would need to show cost effectiveness. Therefore, I required that the staff log every day the types of services they provided, and the time it took to provide those services.

Some months ago I asked two accountants to develop a 1-hour unit cost of service in each of our components, with all administrative costs and overhead divided and incorporated into each unit of service as applicable.

Then it would be a matter of totaling the units of services given any client, and costing those services against the costs of institutionalization.

Knowing that we would have to live with the funding level or costs that we would project, I made some hard decisions as to the sample cases my staff would provide to show cost effectiveness.

1. They must be cases where a doctor, or housing, or Hennepin County had determined that the client had to go into a nursing home. It had to be a qualified person who was not on M.A.O. staff.

2. I wanted different time levels, different types of cases, different combinations of services provided by M.A.O., and some must show how we make every effort to involve relatives, friends, and community resources in order to reduce costs. This is the consortium concept discussed in my opening statement.

M.A.O. Keeps Seniors "at Home"

M.A.O. is also helping to keep seniors in their homes by many lesser kinds of service as previously discussed, ranging from reassurance phone calls to medical intervention by our clinic. Sometimes, depending on the problems, simply having transportation for medical needs or grocery shopping may be the one thing needed to intervene

[1] Retained in committee files.

and help that client, and of course, this type of intervention would be very modest in cost, but we know it works from the many clients we are serving. A research committee on M.A.O. is in the process of looking for funding in order to provide a 3-year study of these intervention points and their impact on seniors' lives and independence, among other things, including cost effectiveness at all levels of care.

Mr. Chairman, I am going to read and explain the background and how we do the formula of costing, using one cost effectiveness case, with some extracts from others. All the cases I am reading from are the hard-type cases I referred to, and therefore, reflect large amounts of services. These people would all be in nursing homes if we were not giving them services.

Case No. 416E: Over a 24-month period, M.A.O. saved the taxpayer $6,026 and each additional month saves $251.09 by maintaining this woman in her apartment, although she has many medical problems, including degenerative arthritis, arteriosclerotic heart disease, developing cataract and aphasia of the left eye.

Case No. 432E: This client was released from the hospital 4 days early when the doctor knew M.A.O. services were committed to her at a savings of $449 to the taxpayer. Each month M.A.O. services are saving $228, although the client has severe Parkinson's disease.

Case No. 431E: This couple is being maintained in their apartment at a savings to the taxpayer of $657.40 a month.

From the cases provided to this hearing, I extracted the following information:

M.A.O. saved the taxpayer $88,710.29 by keeping 27 seniors in their homes where they want to be, for times varying from 10 days to over 3½ years.

Out of this group of seniors, we are maintaining 21 people in their homes at a monthly saving of $4,896.41 and at a yearly saving of $58,756.92.

These figures show that it is really possible sometimes to "have your cake and eat it" in this instance, by providing the care and services in the home that seniors want, as they have stated over and over again at the White House Conference, through the advocacy of the National Council of Senior Citizens, and at State and local levels, and still save the taxpayer money by doing so.

Mr. Chairman, I would like to reemphasize that the basic cost I have given of $450 a month for skilled nursing care, is basic and does not include extras such as additional charges if the patient needs to be fed, or dressed, is incontinent, or has some special handicap such as an amputee. In some nursing homes they even have extra charges for patients who they consider are difficult to get along with.

Mr. Chairman, before I move into my concluding statement, I would like to apologize for any shortcomings in our presentation. I received the news of this hearing from Mr. Halamandaris only 3½ weeks ago, and ours is not an agency providing recreational services or other services, that we could call a halt to temporarily, while we chose from the voluminous records both in our clinic and center, so we did the best we could.

I also wish it had been possible for us to present to you more fully, the extremely comprehensive services that are being provided by the

clinic and M.A.O., and to make you aware of all we hope to accomplish in the future. For, by no means, do we feel that we have finished our task.

M.A.O.-Clinic Merge

By fall, M.A.O. and the clinic will be moving into the same building, at 1801 Nicollet, which will provide us three times the space and bring together for the first time in this country, in one physical plant, a truly comprehensive health program in the fullest sense of the word, for our senior citizens. A model of what we hope will become standard for this country.

Yet, even before we move in we have had to change the building plans and expand the space we need. This should give you some idea of how fast we are growing.

Another unique happening in that building, which I believe will also be for the first time as far as I know, is the joining together of all medical and social supportive services records, to underscore the concept of the new medi-supportive health system, of treating the patient as a whole person and not fragmented amongst the different support systems that he needs.

In the near future, Mr. Chairman, we hope to build a new center for the aging, which will house all the different concepts we have been developing, particularly the consortium concept, drawing together all that is known, the tools to know more and put into action programs which will bring a new age of living to the elderly, not one of simple survival but one of hope that if life is to be prolonged medically, it must also be prolonged meaningfully, that it is not enough to live longer unless the quality of that living is improved.

I wish it were possible to provide these concepts indepth or even briefly, but I know time is running out for this hearing and that is not what I am here for. May I just say this. The reason we need this center, is because this Nation is on a collision course. Every day, we have a buildup of 1,000 senior citizens, over 365,000 a year, yet because of lessened population growth, we are moving toward the years when there will be more elderly retired than younger working people to support their existence. So that, unless we start now, and I mean now, for it is already late, we are giving a grim heritage indeed to our children, one that is truly frightening.

Mr. Chairman, we hear much talk today, of how this country is abusing its heritage and resources. What astonishes me is the failure to realize that any country's greatest resource is its people, of whatever age and today you have heard of the abuse of a large section of our population.

Mr. Chairman, after serving some 28,000 senior citizens in our community, I believe I can draw some conclusions. We know now there are many senior citizens in this country going without vitally needed medical care because they are not eligible for medical assistance, and Medicare which 4 years ago covered approximately 86 percent of health care for the aged, and the appalling fact is, while the coverage is going down, the cost of living keeps rising, so that it becomes harder and harder for these people to try and get supplementary insurance with all its gaps to cover the remainder.

With the added problem of what I believe is a conflict of interest, in that Blue Cross, Blue Shield are in the business of selling that insurance, yet they are also the ones who determine what should be covered under Medicare.

Deductibles Create Barrier

Another conclusion we can draw from the evidence we have heard, is that these seniors find the deductibles and costs above Medicare an insurmountable barrier. That by not providing the coverage to get the health care these people are entitled to, they're going without the most basic necessities of life, which every prisoner serving time in this country received from the Government the seniors have supported in their working years.

Never has so little been done for so many. Mr. Chairman, it was said to me by a doctor, that he didn't see these people dying in the streets, that is true. They die very quietly and the only thing that keeps it from being a national scandal is the fact that the senior citizens have the dignity to die in their own homes or as emergency cases rather than in the streets. It has certainly been proved that should this care be available, with the deductibles and costs above Medicare removed, the senior citizens will avail themselves very rapidly of this opportunity.

Our newsletter has apparently passed from senior to senior across the country. We have received requests from California, Indiana, Wisconsin, Iowa, and from all over Minnesota.

Mr. Chairman, I believe we have also shown you what can happen when a voluntary hospital decides to extend itself and meet its public responsibility to older Americans. And in doing so, carve out a new and vital role for the voluntary hospitals in this country.

We have also heard of the serious situation the voluntary health system is in. We urge your support for their survival. Whatever form the national health bill takes, let us never forget that alternatives are healthy. Single systems stagnate and become complacent and self-serving to the detriment of the people who have no other system to turn to.

The claim of some advocates that large numbers of seniors presently housed in nursing homes can be removed is a myth, it is very difficult to do so once they have been institutionalized. We know, because we have removed some, even though there is no doubt in my mind up to 40 percent of these people would not have needed nursing home care should they have been able to have had the services that we provide.

The answer is to meet the need of seniors before they deteriorate to the point of requiring nursing home care.

Nursing Home Care Cost Prohibitive

There is a need for greater nursing home coverage. There are thousands of elderly who need such care, who cannot afford the care they need. Nursing home care will always be necessary for a certain segment of the population.

Such care should be provided by an expanded Medicare program so that all people over 65 can benefit when they need it. Today's nursing

home care is available only to the very rich who can pay their own way or to the very poor who qualify for Medicaid. The central need for most of the elderly is supportive services and health care such as M.A.O. provides. I want to emphasize again, that our services evolved out of a reading of what the seniors themselves asked for and needed. This is why I am encouraged by the Kennedy-Mills bill. It recognized that what seniors need is something more than just a nursing home or medical care by itself. What is needed is a central agency, such as ours responsible for determining what are the needs of individual seniors, then trying to meet their needs, by providing a comprehensive program of services.

Mr. Chairman, we have concluded that 20 percent or 38,800 seniors in Hennepin County, have need of our services, either on an episodic or ongoing basis. Therefore, it would be a conservative estimate that 20 percent or 4 million senior citizens in this country have such a need and you may well ask where is the money to come from. Well, first I would like to say that the money has got to come from somewhere. The thousands of senior citizens we have seen in these last few months have shown us the next crop of senior citizens due to be incarcerated in nursing homes, unless they get the help they need now. They don't even know about the few programs in existence to help them. In reviewing 3,000 case histories, we found that 1,720 of them were eligible for various assistance programs they knew nothing of and I don't have the staff to help them. In those few months, just 23 of my staff put in 4,964 volunteer hours. We don't have the money to pay them overtime. They are so concerned about these people they are willing to work until they drop, but it can't go on. And again I point out to you, that we may not even have these staff in 1975, unless of course, we turn our agency around and serve those who can afford to pay. Those people also need help and are willing to purchase our services.

Mr. Chairman, there is a place where we can find the money to cover the health costs and the supportive services. I hope you will find what I am going to tell you now of dramatic interest. If you take our combined grants from Model City and title III funding, which comes to $351,458 and divide it by the money we saved the taxpayer from title XIX funding for 21 people, which is $58,756, for a year, you will find that we only need to keep 126 people a year in independence through our medi-supportive services and our total funding could be paid for by the title XIX money we saved, instead of you paying the nursing homes to keep people where they don't want to be and don't have to be, and in the bargain we will throw in free, our support of the remaining 7,000 plus the 20,000 we are serving through voluntary action, plus the fact that we have provided a new role for our voluntary hospital system to survive in this country.

If you support senior citizens in independence by these methods, the money you will save under title XIX can be reapplied to pay for better Medicare coverage, the supportive services such as M.A.O. provides, and to giving a realistic reimbursement to the hospitals to cover their costs, so that they in turn can serve the elderly as Abbott-Northwestern Hospital, Inc. has.

By no means are we suggesting this is the only alternative, but we do know it is one that works. Otherwise with a rapidly increasing and

deteriorating elderly population, you will just be paying more and more anyway to institutionalize these people.

Mr. Chairman, we know what we're saying is true, and we are willing to open our records to prove it.

May I end with a quotation from Aristotle which Senator Ribicoff used in his book:

> If we believe men have any personal rights at all as human beings, they have an absolute rght to such a measure of good health as society, and society alone, is able to give them.

Mr. Chairman, if I may, I would just like to speak to you and summarize some of the things we have been trying to get to you today.

First of all, I think you know from your experience all of the things we are talking about are things that senior citizens need.

I am sure you are aware of the advocacy of the National Council of Senior Citizens, that fine organization. What happened was some years ago, my involvement with Abbott Hospital, I became aware that the volunteer hospitals in this country are in bad trouble.

I believe that any administrator that you talk to will tell you that our volunteer system is probably going down the drain in 5 years. Now, I do not consider that as a good thing.

I know that some people are afraid of this new approach, in trying to introduce socialized medicine. It is not true. I do not believe in one system. I am afraid of one system. I think you become complacent.

I do believe that we can take our health systems and use them in innovative ways with programs like ours to provide the services that people need at a lot less cost.

Now, that was just a hypothesis a few years ago. Since the beginning of the M.A.O. clinic I have kept records, shown every service we gave, the cost of that service, the time of that service and in the last few weeks to prepare for today, I did some evaluations of them and I wrote up about 27 cost analyses that could be done now—we have the formula on any client that we have—and do you know, of 27 people, keeping them in their homes where they want to be, we saved over $68,000 in title XIX money.

What I am talking about is not necessarily a lot more money but a redistribution of that money. Every year we are building up seniors in this country to a rate of 365,000 a year.

Now, where are you going to get the care to provide for these people? You have a choice. If you do not take care of the medical and supportive needs and provide more and more title XIX money, we are saying that is not commonsense and it is not what the seniors want.

By using the volunteer system, by creating funding for programs like ours, you can keep the seniors where they want to be and at the same time, not increase your costs if you reapply that money.

Among the cases we gave to you, there are 21 people who we are still keeping independent. It was not our view that these people should be institutionalized. I was very careful to make my staff choose cases where a doctor, a county person, somebody else had said this person is to be institutionalized, so it was irrefutable.

Those 21 people we are keeping in independence saved title XIX money, $55,000 a year. Now, if you put that into our budget, Senator, you come out with the fact that all we have to do is to keep 126

seniors in independence a year and the money for our budget can come from the savings we have provided you in title XIX.

We are keeping around 8,000 people in various levels of medical support, we are providing volunteer services to about 20,000, and in the bargain, I truly believe this might be the system that will best utilize our voluntary system and keep it alive.

That is what it is all about.

Senator MUSKIE. It is a very impressive story, Mrs. Krause.

PROGRAM ECONOMICALLY VIABLE

Let me ask you—it is implicit in what you testified—but I can make it explicit. I gather you have found this program economically viable?

Mrs. KRAUSE. Yes, sir.

Senator MUSKIE. And you are not going out into the community to beg for money to support it; you are doing it out of the Medicare payments?

Mrs. KRAUSE. No, let's understand something. We do not get the money. The nursing homes do it this way.

What we are suggesting to you is that this is the way of reapplying those funds. At this time, we are being paid with a consortium of Abbott absorbing the costs because they believe in what we are doing. They are the best judges; they have watched us for 5 years.

Senator MUSKIE. Do you have any figures on what it is costing Abbott?

Mrs. KRAUSE. No.

Mr. ADAMOVICH. They are included in the testimony, Senator.

Senator MUSKIE. All right. We will see these. Incidentally, you and Mrs. Krause are going to be here tomorrow?

Mr. ADAMOVICH. Yes.

Mrs. KRAUSE. We would be glad to.

Could I tell you this formula, how you arrive at the cost is you first take the cost of basic nursing care, whatever it is a month, you deduct from that the senior's income—because if he was in a nursing home, it would be applied to both the cost of care—and then you deduct the services we have given, the cost of those, because they would not be needed and then that is what you save Medicaid.

Mr. ADAMOVICH. Senator, in addition to expressing my appreciation for allowing us to make this statement today, I would like to comment that it is usually our custom, and it has been for years, to remain in the low profile for delivering services, but we really do believe that the future of health care in this country is in some jeopardy and that our usual desire is something we preferred to give up today, in the light of what we think is really a danger, particularly if we choose to pattern national health insurance directly after Medicare payments.

We would simply translate the problems that are presently the problems of senior citizens to a very large segment of the American public and I think that ought to be avoided.

Mr. HALAMANDARIS. I would like to compliment all of you. I guess I, better than anyone else in this room, know of the amount of work and effort to put all this together. I must say under the time constraints,

you did admirably. I hope we have helped tell this story to the American public, because this is happening to the millions who are not receiving the care they need.

I want to nail down a couple of things before tomorrow.

First of all, with respect to the minutes [1] of which we have a copy and which were taken by Mr. Kramer, there were other people present at that meeting, and am I correct, that have provided the committee with sworn statements verifying the minutes of the meeting?

Mrs. KRAUSE. Yes, they are sworn affidavits. Excuse me, Mr. Chairman, our two attorneys are with me today. They took the affidavits.

Mr. HALAMANDARIS. These affidavits certify that the minutes are an accurate reflection of what took place at the meeting. Is that correct?

Mrs. KRAUSE. Yes.

Mr. HALAMANDARIS. Second, I would like to clarify the record. The kinds of problems, the claims which were rejected, you contend were far from being typical physical examinations. The tests were ordered as a result of pathology? I see some nodding of heads. Dr. Farber, could I have your response for the record?

Are these tests the result of pathology or were they mostly physical examinations?

Dr. FARBER. All of these tests were results of pathology.

Mr. HALAMANDARIS. Would you agree with Dr. Bonewell's statement in the minutes, that not to order some of those tests would constitute malpractice?

Dr. FARBER. Correct.

Mr. HALAMANDARIS. Third, I was under the impression that any combination of EKG laboratory tests and X-rays, appearing together, were automatically taken for a physical examination and rejected. Is that what has been happening?

Mr. ADAMOVICH. May I clarify one point there? On the laboratory test, it has been our custom to use what is called the multichannel battery of tests because each of these patients are requiring one, two, or three tests, minimally.

It is much less expensive to deliver a battery. This is why they see one large number. It gives the 16 tests at once in a cross section.

Mr. HALAMANDARIS. Have you been required to provide documentation over and above what is ordinarily required for Medicare in order to receive payment?

In other words, have you gone to extremes to clarify the statements and bills you are submitting? Are they well documented and so on?

Mr. ADAMOVICH. Yes, sir; this is true and the appeals process is not complete yet.

Mr. HALAMANDARIS. Will you give us some indications of the extra procedures you employed to show the claims are justified?

Mr. ADAMOVICH. I think Mrs. Pearson might be able to testify to that.

Mr. HALAMANDARIS. Just quickly.

Mrs. PEARSON. There is an extra form you tack on. You make copies from the medical record itself, Xeroxing sections of the medical record.

Mrs. KRAUSE. An enormous detail of work.

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[1] See appendix, item 6, p. 1323.

Mr. HALAMANDARIS. Which is not normally required?

Mr. ADAMOVICH. And we have some forms here.

Mrs. KRAUSE. In the minutes, Ms. Blood admits this.

Mr. HALAMANDARIS. Two last quick questions. It is my understanding, and I would like your comment on this, that identical claims which are now being rejected by Blue Cross and not being paid, were paid previously and you had examples for presentation to the committee some months ago which were paid, and others submitted 2 months ago which were not?

Mr. ADAMOVICH. About 12 of them. There are probably many more but in the interest of time, it showed the two together; the one paid prior to 1973 and the one rejected after.

Mr. HALAMANDARIS. Is it my understanding that these claims, if submitted by the hospital itself, or by another clinic, would be paid by Blue Cross of Minnesota? Is that true?

Mr. ADAMOVICH. I can say we had not had problems with this type of claim in another context.

Mr. HALAMANDARIS. No problem when the hospital itself submits similar claims?

Mr. ADAMOVICH. No, that is correct.

Mrs. KRAUSE. We can say, because we handled the Medicare forms prior to the expansion of the clinic, we did not have problems either.

Mr. HALAMANDARIS. It has been since the expansion of the clinic and the innovation of accepting Medicare as full and final payment that claims were refused as "diagnostic screening."

Mr. ADAMOVICH. Yes.

Mr. HALAMANDARIS. Lastly, would Dr. Farber provide for the record some examples of what you would call Medicare slot-machine language?

By that, I mean language which pays off in terms of Medicare. You mentioned to me that you never write down "migraine headache." You write down "suspicion of."

Dr. FARBER. One would have to say "brain tumor suspect" or one might have a dizziness attack, that is no good.

It is an impending stroke. Someone has to be careful and cautious to show attestive in diagnostic possibilities are there but that, I suspect very definitely that this is the disease.

Mr. HALAMANDARIS. Would the physician present for the record a list of the kind of language you just used, illustrations of what pays and what does not pay, or other "game playing" you have to go through to receive payment?

Those are the questions I have.

Senator MUSKIE. Thank you all very much. We stand in recess.

[Whereupon, the subcommittee recessed at 12:30 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

ITEM 1. STATEMENT OF LYNN McCARTHY,[1] CHAIRMAN, SENIOR CITIZENS COMMITTEE, JUNIOR LEAGUE OF MINNEAPOLIS, MINN.

To whom it may concern: For a number of years, members of the Minneapolis Junior League had expressed an interest in a project in the Senior Citizen area.

The League thoroughly investigated the needs of Seniors and also the existing agencies that serviced these needs. It was determined that no other agency, public or private, provided the comprehensive range of services that were made available by the Abbott-Northwestern/Minneapolis Age and Opportunity Center (M.A.O.) partnership.

M.A.O.'s purpose for being and the League's purpose for entering the Senior Citizen area were much alike. We all wanted to serve the needs of the increasing number of Seniors in our community and hoped to implement programs to help them maintain their independence and their dignity.

It is unrealistic to think that federal dollars can provide all the funding necessary for an agency such as M.A.O. to exist and to thrive. Therefore, M.A.O. has established a consortium of community partners in order to achieve its goals.

One of its partners now is the Minneapolis Junior League.

The League is providing moral, financial and volunteer support to M.A.O. and in return M.A.O. is providing League volunteers with a comprehensive training ground and equipping them to work efficiently in any level of commitment. The volunteers are receiving first hand exposure to the problems and pressures of a public agency operating under federal financing.

Our financial support has been given in the form of 1½ years of salary for a volunteer co-ordinator hired to expand the M.A.O. volunteer effort.

Our volunteer support can be identified most effectively by a run down of what has been accomplished by League volunteers over the past two years of our association with M.A.O.

During the first year of our involvement (1972–1973) we participated in the delivery of most of the services offered by M.A.O. The League co-operated with M.A.O. and the Minnesota Restaurant Association to expand their "Meals in the Community" program. We increased the number of patricipating restaurants in the program by determining and reporting to the Association the existing restaurants along established bus routes. We prepared and found funds to print a full page newspaper advertisement detailing participating restaurants and their various food plans. 5,000 new Senior Citizens joined the program after the appearance of the ad. 80 new restaurants joined the program due to League efforts.

One of our Leaguers, a Registered Nurse, became very active in the clinic operation and now, three years later, still maintains an important position there.

A member of our committee is appointed each year to sit on the Board of Directors of the Minneapolis Age and Opportunity Center.

In 1973–1974 M.A.O. became barraged with applicants for their expanded Senior Citizens Clinic program and the League became involved again. Nine additional phone lines were installed at M.A.O. for increasing calls and these were manned by M.A.O. staff and Junior League volunteers. Hundreds of phone calls

[1] See p. 1256, statement of Daphne Krause, executive director, Minneapolis Age and Opportunity Center, Inc.

were received each day for a month's duration. Leaguers were involved in the interviewing process as the Seniors came in for registration into the program.

The "Operation Grandparent" program benefited by the addition of a League member to its working staff. Many of our committee were involved in one-to-one projects such as home nursing, home visiting and telephoning.

M.A.O. provides so many new challenges for volunteers. It was suggested by Daphne Krause, the Executive Director, that the League might like to pick up on the idea of establishing a Senior Citizen Clinic Blood Bank—in conjunction with the War Memorial Bank in Mpls. This bank was set up by the League. The bank now serves members of the Senior Citizen Clinic who need blood replaced but who have neither the friends, nor relatives, to replace it. Without this service they would have the burden of paying $25.00 per pint for the first three pints of blood, after which Medicare would assume the costs.

It was decided that when our Blood Bank reserve total reached 100 pints—we would give to all Senior Citizens in Hennepin County who met the low-income requirements and had no one to replace the blood—the opportunity to obtain this blood. This was an objective that I thought might be met in a year or so provided that a major publicity campaign was set up. But I was wrong. M.A.O. staff members began to contribute blood. The President of the Junior League and many members and their husbands gave blood and so did friends of the agency. A tremendous contribution of blood was made by the student nurses of Abbott-Northwestern Hospital School of Nursing. The grand total for only 8 mos. in existence is 212 pints of blood for the newly-formed bank.

In the coming year I see the League again concerned with the Blood Bank—this time involved in setting up a city-wide drive for blood.

We hope to gain experience in developing legislative approaches to some Senior Citizen problems.

We will maintain an active part in the Senior Citizen Clinic and assist M.A.O. in combining all their Services under one roof at a new location.

Our volunteers will visit Senior Citizen Clinic patients at Abbott-Northwestern Hospital.

In the coming year our volunteers will assist M.A.O. in its long range goal—to open a major new center in Mpls. for Senior Citizens. This center will serve as a national research and demonstration facility for Senior Citizens.

M.A.O. has effectively created a role for a volunteer organization operating within an established agency.

I believe that the partnership we now maintain has proven beneficial to all concerned.

Beneficial to: M.A.O.; to Abbott-Northwestern Hospital; to the Minneapolis Junior League members; and most important, this partnership has been beneficial to the Senior Citizens of our community who are trying so hard to maintain their independence.

ITEM 2. MINNEAPOLIS AGE AND OPPORTUNITY CENTER, INC., SERVICES DELIVERED OVER THE PAST 5 YEARS

M.A.O. is now supporting approximately 8,000 Senior Citizens with various levels of MEDI-SUPPORTIVE SERVICES and 20,000 Senior Citizens in Miscellaneous services through M.A.O. programs in the private sector.

M.A.O. Medi-Supportive Services Provided Through Federal Funds

These services are provided in the following categories:

HOME DELIVERED MEALS PROGRAM

The home delivered meals service is a professional food service offering home delivered meals to M.A.O. clients, who either for short or longer periods of time are unable to manage their own food preparation. Meals are made available 7 days a week for those who qualify. Home delivered meals offers a complete hot balanced dinner and evening cold meal, delivered once a day to a person in his own home. A regular planned cycle of menus is offered according to a qualified dietitian. The professional food service kitchen of Abbott-Northwestern Hospital where the food is prepared is licensed by inspection of the Minneapolis Health Department as meeting all standards of food handling and preparation.

EMPLOYMENT SERVICES

Senior Citizens needing employment who are desocialized, handicapped, or have special employment problems are provided with specialized professional employment services to deal with the obstacles confronted by this population when interacting with the labor and job markets. This may include the development of jobs, job referral, counseling, and follow-up services after job placement. Other M.A.O. services may be needed to help these clients.

HOMEMAKER SERVICES

Homemaking and personal care services are provided to maintain, strengthen, and safeguard the functioning of eligible persons in their own homes when no responsible person is available for this purpose.

CHORE SERVICES (HANDYMAN)

Chore services provide simple household repairs, maintenance, with special emphasis on trying to correct hazards in the home to eligible clients.

TRANSPORTATION SERVICES

Transportation is to bring services to the people and people to the services. Transportation is used to secure necessary diagnostic, preventive, remedial, ameliorative, and other health services, for emergencies, to obtain food stamps, groceries, housing, welfare, relief, legal services, etc.

LEGAL SERVICES

The M.A.O. attorney is available by telephone as well as by appointment to assist those clients who are eligible to obtain legal services. The attorney does not handle criminal matters or cases that can generate a fee. Appropriate referrals are made. Notary services are available at the center or in the home for senior citizens who are unable to come to the center.

HENNEPIN COUNTY BAR FOUNDATION

M.A.O. has received a grant for a legal clerk to assist the M.A.O. attorney, and expand services from the Hennepin County Bar Foundation.

COUNSELING SERVICES

Counsellors evaluate and assess each individual for services, and either provide such service or initiate referral to the appropriate M.A.O. component or community agency. Counsellors follow up each inter or intra agency referral to ensure that appropriate and effective services are provided and that the individual's needs are satisfied. Counselling employs effective case finding techniques to ensure availability of service to needy individuals of the client population providing whatever counselling services are necessary.

INFORMATION AND REFERRAL

Information and referral's primary function is to respond to the request of those people needing help with the necessary information, and assistance to obtain it, including escort services where necessary, and transportation if needed to get this service. Information and referral staff maintain accurate and up-to-date information concerning all M.A.O. services and other community services and resources.

VOLUNTEER—SOCIAL—EDUCATION

Volunteers are provided in a number of activities, such as transportation, companionship services, grocery shopping, escort service, reassurance phone service, education on Senior Citizens' problems as expressed by Senior Citizens, and resources for Senior Citizens in the community. Volunteers provide certification for the "Meals in the Community Program", etc. The Volunteer Coordinator is funded by the Minneapolis Junior League.

HEALTH SERVICES

Services to meet health needs include assistance in securing necessary diagnostic, preventive, remedial, ameliorative, and other health services, including prosthetic, orthoptic, and assistive aids available under medicare, medicaid, or other agency health service programs, and from other agencies or providers of health services.

Health services also include assistance in making arrangements for transportation to and from health resources, and maintaining necessary liaison with the family, physician, nurse, institution, or other provider of health services to assure the provision of social service necessary to carry out medical recommendations with the client, and family when available.

ADVOCACY

The M.A.O. staff take advocacy action on behalf of their clients as needed. The M.A.O. Board of Directors, acting on their knowledge from the community, and/or information received from the groups they represent, direct and assist the executive director to take advocacy action on a broader basis. Common concerns of Senior Citizens are thus considered in an active and organized way by the people most affected, and necessary action is taken.

M.A.O.'S PROGRAM WITH THE PRIVATE SECTOR CONTAINING NO FEDERAL FUNDS

The M.A.O. governing board has felt from the beginning that federal funds should be used only for programs not available in the private sector, or are financially too great a burden for any part of the private sector to carry out alone. To this end M.A.O. has developed a number of programs cooperating with various community groups in the private sector to alleviate problems of our Senior Citizens. While these programs contain no federal funds, they are administered by the staff of M.A.O.

ABBOTT-NORTHWESTERN HOSPITAL/M.A.O. SENIOR CITIZENS CLINIC

We have found a number of seniors who have no private physician and who have had difficulty obtaining preventive medical care as well as satisfactory care and follow-up for acute problems. The Abbott-Northwestern Hospital/M.A.O. Clinic provides a preventive medical service, a Diagnosis and Treatment Center, Emergency Service, Counselling Service on health matters where necessary, and in-patient service where needed.

Abbott-Northwestern Hospital is the provider of the medical facilities, supervision, and necessary nursing and technical personnel. Medical care is provided by members of the Abbott-Northwestern Hospital Medical Staff as private practitioners. Since there are no federal funds, costs are paid by insurance, Medicare, or private resources. All referrals to the clinic must come through M.A.O.

M.A.O. facilitates the senior's entry into the health delivery system by helping the senior in the Abbott-Northwestern Hospital/M.A.O. Clinic or any other health facility of his choice. We assist with Medicare and other insurance forms and with obtaining additional financing when the client is eligible.

Besides transportation to the clinic, M.A.O. stands ready with all of its medi-supportive services if the doctor who is director of the clinic prescribes them. By joining the high standard of professional care provided by the Abbott-Northwestern Hospital with the medi-supportive services of M.A.O. the senior receives a comprehensive service of medical care unduplicated elsewhere without the feeling of being passed around from agency to agency.

For recent program development see attached newsletter.

"MEALS IN THE COMMUNITY"—MINNESOTA RESTAURANT ASSOCIATION/M.A.O.

The crisis of hunger facing our senior citizens cries out for a solution, not only on the grounds of compassion for hungry people, but also because of the health and economic factor that hunger leads to anemia and other symptoms often confused with senility, and finally on to a general deterioration of health and possible institutionalization.

M.A.O. wrote the program, and in cooperation with the Minnesota Restaurant Association, developed it, a program whereby seniors were certified to buy low

cost nutritional meals at cooperating restaurants during off-peak hours, using identification cards provided by M.A.O. at no cost to the senior.

Currently 20,000 seniors are certified to purchase these meals at cooperating restaurants in the Metropolitan area. Again, there are no federal funds involved, but the M.A.O. staff administers the program as well as providing back-up services where a need arises.

By a combined effort of groups in the private sector working with M.A.O., some hunger and nutritional problems that afflict our seniors are being alleviated, while still respecting the pride and dignity of the seniors who through no fault of their own are unable to obtain the food needed to maintain their health.

This program also provides a means for helping the senior citizen who is lonely and isolated to get out in the community and find new friends, while enjoying the benefits of good food. This program is now expanded to include younger blind and disabled.

ST. MARY'S FRIENDS—M.A.O. CRISIS FUNDS

Emergencies and circumstances frequently arise that traditional sources of help don't cover or that need to be handled in a flexible and immediate way. To deal with these situations a unique partnership was set up between M.A.O. and St. Mary's Friends whereby St. Mary's Friends provides crisis funds making it possible for M.A.O. to move quickly, bringing immediate help where it is needed with the flexibility to cover a multitude of problems that affect senior citizens, i.e., emergency food, clothing, colostomy supplies, glasses, dental care, etc.

The crisis funds supplied solely by St. Mary's Friends also enables senior citizens (no geographic boundaries) an opportunity to make use of M.A.O. services. Besides providing the crisis fund with money, St. Mary's Friends help senior citizens in other ways such as taking them shopping, to the doctor, or to church, visiting them when they are alone, or just calling them on the phone to talk—the little things that can be so big to someone who is alone.

"TELE-CARE" AN ABBOTT-NORTHWESTERN HOSPITAL SERVICE WORKING WITH M.A.O.

Tele-care is a service for those who live alone and require a reassurance phone call once every 24 hours, every day of the year, including Sundays and holidays. A client registering for the tele-care program calls the tele-care phone number at Abbott-Northwestern Hospital every morning to let them know she is all right. If the client fails to call in, a volunteer will call her. If this procedure produces no results, a neighbor will be called whose name has already been given by the client to the tele-care service. Finally, if there is no good explanation of the client's failure to answer the phone, a counsellor from M.A.O. will go immediately to the home to see if the client is all right, and provide any necessary service.

24 HOUR EMERGENCY PHONE SERVICE

Emergencies don't follow an 8:30 to 5:00 schedule and so M.A.O., in cooperation with Abbott-Northwestern Hospital has set up a 24 hour emergency phone service. During office hours, of course, the M.A.O. staff responds to emergency calls, but after hours, should an emergency situation occur, a senior can call the emergency number at Abbott-Northwestern Hospital where the operator has the number of the M.A.O. staff member who can help. M.A.O. staff who participate in the program have volunteered and receive no remuneration for this service.

"OPERATION GRANDPARENTS"

Federally funded programs will never be able to fully meet the needs of the thousands of seniors living in loneliness and isolation of our major cities. This is the conviction that led to a program called "Operation Grandparents" whereby senior citizens are matched with volunteers in a mutually rewarding relationship.

While "Operation Grandparents" ostensibly is meant to dissolve seniors' feelings of isolation and lack of personal worth, it in reality provides thousands of medi-supportive and friendly visitor services that existing money could never buy.

The purpose of the program is two-fold in that the seniors are given services, companionship and the knowledge that someone cares. Volunteers will receive a

sense of personal fulfillment that comes from literally helping another human being.

"Operation Grandparents" is coordinated through M.A.O. in cooperation with Stuart A. Lindman of Metromedia Television Station WTCN (Channel 11). M.A.O. provides the administrative help for the program, much of it on volunteer time, and stands ready to offer its expertise as a back-up should problems arise. Again, no federal funds are involved and yet services to seniors are being multiplied.

JUNIOR LEAGUE—M.A.O.—ABBOTT-NORTHWESTERN HOSPITAL

This program in conjunction with the Junior League and Abbott-Northwestern Hospital is to undertake an intensive involvement leading to a first-hand understanding of M.A.O. services for the elderly in order to help the M.A.O. program grow.

The Junior League has funded a volunteer coordinator to coordinate and build the volunteer services in conjunction with other M.A.O. services.

Coordination With Public Agencies

MINNEAPOLIS PUBLIC LIBRARY/M.A.O.

Agreement to coordinate library services to the aged through the *Minneapolis Public Library's Program "Service to the Homebound."*

"Service to the Homebound"

Objective: "It shall be the objective of 'service to the homebound' to provide free and ready access to the materials of the Minneapolis Public Library for the pursuit of education, information, and creative use of leisure time to eligible persons of all ages who cannot come to the library because of physical incapacity."

INFORMATION FROM "SERVICES TO THE HOMEBOUND" BROCHURE

"Are you confined to your home by illness, disability, or advanced age? The Minneapolis Public Library would like to share with you the world of books. Through books you can visit the past, present, the future. You can visit the four corners of the earth, and even outer space.

At no charge, a friend of the Minneapolis Public Library will deliver library materials to your home once every three weeks. This friend will also take your requests for library materials you would like to borrow, and will return the materials to the library for you. In addition to books, you may borrow magazines, paperbacks, records, and cassettes.

The library now has many books printed in large type for those who find it difficult to read regular print. If you have trouble with your vision, request these large print books from the friend who visits you."

POLICE REFERRAL PROGRAM

The Minneapolis Police Department's Referral Program provides for direct contact between patrolmen and the staff and services of M.A.O. The senior citizens are often in crisis situations that come to the attention of the police department such as:

(A) Theft, need for emergency funds,
(B) Need for emergency food,
(C) Need for emergency housing,
(D) Need for emergency transportation,
(E) Need for health services,
(F) Need for counselling during crisis situation,
(G) Assistance with lost papers such as medicare card, etc.
(H) Need for legal services.

ITEM 3. NEIGHBORHOOD ORGANIZATIONS SUPPORTED BY ABBOTT-NORTHWESTERN HOSPITAL; SUBMITTED BY GEORGE ADAMOVICH, ADMINISTRATOR, ABBOTT-NORTHWESTERN HOSPITAL, INC., MINNEAPOLIS, MINN.

Neighborhood Counseling Center.

Nursing services to housing programs for the elderly (Abb-NWH was the first Minneapolis hospital to provide this service).

Nursing services for U-Meet-Us program, a service program for Black senior citizens.

Nursing services for South High project, which serves senior citizens in a Minneapolis neighborhood (a program supported by M.A.O.).

Major sponsor of Southside Community Clinic, providing medical and other services to a low-income Black population.

Neighborhood Involvement Program (NIP) receives supplies and cash support for personnel for this medical service program.

The C.I.P. (Community Involvement Program) a program for mentally retarded residents sponsored by a local church uses Abbott residential facilities and medical services.

The newly organized Stevens Square Citizens organization is receiving assistance in organizing.

The Metro Community Health Consortium (an organization of community clinics) is receiving support for office rent and use of copying services.

The Gay Community Services receives office space and services.

M.A.O.

Loring-Nicollet Community Council.

Patients referred to Abbott by local health services are often non-pay, i.e., assisting these programs cannot be considered a marketing technique.

According to an analysis prepared by Ken Morgan for eight months in 1973, expenses to Abbott-Northwestern of these programs for 12 months would be $105,600.

ITEM 4. A SUMMARY PROFILE OF THE ELDERLY IN MINNESOTA; SUBMITTED BY GEORGE ADAMOVICH, ADMINISTRATOR, ABBOTT-NORTHWESTERN HOSPITAL, INC., MINNEAPOLIS, MINN.

A SUMMARY PROFILE OF THE ELDERLY IN MINNESOTA

I. *Introduction*

Frequently the validity of projecting the findings of demostration projects to different settings is challenged. The characteristics of target populations or other situational factors may vary significantly between projects making such projections impractical. This phenomenon is especially true for demonstration projects dealing with social issues.

For this reason, in discussing the success of M.A.O.'s Medi-Supportive Services Program, it is desirable to comment on the situation of the elderly in Minnesota and its comparability with other parts of the country. Three brief comparative profiles have been drawn:

(1) Population characteristics of the elderly.
(2) The availability of health manpower and facilities.
(3) The utilization of health services.

II. *Population Characteristics*

As a percent of the total population, Minnesota's elderly account for 10.7%, according to 1970 census figures, compared to 9.9% nationally. 9.7% of the population in Hennepin County, the base for M.A.O. operations, is age 65 or older.

TABLE A.—POPULATION CHARACTERISTICS OF MINNESOTA'S ELDERLY—1970 CENSUS

	Total population	Percent change since 1960	Number over age 65	Percent change since 1960	Percent of population over age 65
Abbott-Northwestern "neighborhood" (32 census tracts)	104,422	----------	18,526	----------	18.1
Minneapolis	434,400	----------	65,235	----------	15.0
Hennepin County	960,080	+13.9	92,953	+13.8	9.7
Metro area	1,874,380	+22.9	163,746	+16.8	8.7
Minnesota	3,804,971	----------	407,132	+11.5	10.7
United States					9.9

An identification of the residences of the elderly in the Metro area reveals a proportionally higher number are living in the central cities of Minneapolis and St. Paul as opposed to outlying suburban areas. The central cities contain 26.2% of Minnesota's noninstitutionalized aged vs. 19.6% of the state's total population.

Table B. Pecentage of Population Over Age 65 Living in Institutional Settings

[In percent]

Hennepin County	7.5
Metro area	7.9
United States	4.8

Although a similar percentage of people in Hennepin County and nationally are age 65 or older, significantly more of these people in Hennepin County live in "institutional" settings. Of these, approximately 70% live in facilities classified as "skilled nursing" or "intermediate Care I."

III. *The Availability of Health Manpower and Facilities*

The availability of active physicians per 100,000 population in Minnesota appears to approximate national figures closely. Other selected categories of ancillary health personnel, such as registered nurses, exceed national averages.

TABLE C.—THE AVAILABILITY OF HEALTH MANPOWER PER 100,000 PEOPLE

	Number of physicians	Number of dentists	Number of registered nurses
Metro area	106.7	72.6	546.7
Minnesota	101.4	58.4	468.5
United States	105.0	47.0	353.0

In terms of health facilities, Minnesota ranks 16th nationally in the number of hospital beds available, 25th in the availability of extended care beds, and 26th for home health agencies:

TABLE D.—THE AVAILABILITY OF HEALTH FACILITIES PER 1,000 MEDICARE ENROLLEES

	Number of Medicare enrollees		National rank		Number of hospital beds	National rank	Extended care beds	National rank
	Hospital program	Medical program	Hospital	Medical				
Minnesota	407,000	395,000	14	14	46.7	16	15.4	25
United States					42.2	----------	17.3	----------

IV. *The Utilization of Health Services*

It appears that Minnesota's elderly are hospitalized at a rate exceeding U.S. averages, but experience fewer extended care admissions.

TABLE E.—THE UTILIZATION OF HOSPITALS AND ECF'S BY MEDICARE ENROLLEES

	Number of Medicare enrollees—national rank		Number of hospital admissions per 1,000 Medicare enrollees	National rank	Number of ECF admissions per 1,000 Medicare enrollees	National rank
	Hospital program	Medical program				
Minnesota	14	14	364	10	22.0	24
United States			307		25.8	

In terms of benefits paid for health services on behalf of Medicare enrollees, Minnesota exceeds national averages for the hospital portion of the program, and is less than national averages for the medical portion of the program.

TABLE F.—AVERAGE MEDICARE BENEFITS PAID TO USERS OF HEALTH SERVICES

	Average benefits per Medicare enrollee using services		National rank	
	Hospital program	Medical program	Hospital program	Medical program
Minnesota	$267	$66	11	16
United States	237	87		

V. *Summary*

The few statistics presented, point out:

(1) That Minnesota is very similar to national averages in terms of percent of population age 65 or older, in the availability of health manpower and resources, and in the utilization of health services.

(2) That, in spite of the similarity to national *averages,* Minnesota generally ranks higher than other states in these same categories (e.g. more hospital beds available).

(3) That a significantly higher proportion of Minnesota's elderly reside in institutional settings.

If anything, it might be said that the environment in which M.A.O. operates in many ways is more favorable than what one might find in other parts of the country—which makes the experience of M.A.O. even more dramatic.

Sources:

(1) US Census, 1970—General Population Characteristics: Minnesota.

(2) "Population Projections", Prepared by the Vital Statistics Section, Minnesota Department of Health.

(3) "Needs and Problems of the Elderly Population of the Metropolitan Area", September, 1973, Metro Council.

(4) "Health Planning Data Series: A Technical Report on Health Manpower", State Planning Agency, CHP, April, 1974.

(5) "Minnesota Health Personnel Data Book", Northlands Regional Medical Program, 1969.

(6) "State Data Book on Aging", Governor's Council on Aging, 1969.

ITEM 5. LETTERS OF SUPPORT FOR CLINICAL PHARMACY FROM HUGH F. KABAT, PH. D., PROFESSOR AND HEAD OF CLINICAL PHARMACY; AND LAWRENCE C. WEAVER, DEAN OF PHARMACY, UNIVERSITY OF MINNESOTA

UNIVERSITY OF MINNESOTA,
CLINICAL PHARMACY,
Minneapolis, Minn., June 20, 1974.

Mr. GEORGE ADAMOVICH,
Administrator, Abbott Hospital,
Minneapolis, Minn.

DEAR MR. ADAMOVICH: We at the College of Pharmacy are most enthusiastic and interested in the proposal advanced by Dean Watson and Richard Levine for a special pharmacy program for the aged.

For several years we have studied the special problems of the aged relative to drugs. Our studies led us to establish special coursework for senior pharmacy students in which they serve as triage officers to help the aged to enter the health care system, monitor their therapy for drug interactions and adverse reactions and counsel them regarding the need for compliance with their therapeutic regimens.

We are most supportive of your proposal. I would hope that we could perhaps establish an instructional affiliation between our organizations sometime in the future to collaborate on these areas of common interest.

Sincerely,

HUGH F. KABAT, PH. D.,
Professor and Head.

UNIVERSITY OF MINNESOTA,
COLLEGE OF PHARMACY,
Minneapolis, Minn., June 20, 1974.

Mr. GEORGE ADAMOVICH,
Administrator, Abbott Hospital,
Minneapolis, Minn.

DEAR MR. ADAMOVICH: The program proposed by Mr. Dean Watson, Chief Pharmacist, and Mr. Richard Levine will improve the quality of health care of the aged. Indeed, there may be a resultant economic saving for these patients.

We have been working with senior citizens' groups for several years to assist them in drug-use control. We find serious overuse of medications to the detriment of the patient's health. Our students are being exposed to these problems and participate in their solution. Your proposal to staff your new clinic with pharmacists with a patient-oriented background will make possible some of the innovations in drug-use control which have been developed. We offer you our assistance in any way that we can to make your proposed program as productive as it can become. After the needs of the patient have been assured, perhaps it would be possible to consider this clinic as a teaching unit in collaboration with our college.

Best wishes in this interesting and exciting venture.

Sincerely yours,

LAWRENCE C. WEAVER, *Dean.*

ITEM 6. BACKGROUND ON ABBOTT-NORTHWESTERN/MINNEAPOLIS AGE AND OPPORTUNITY CENTER, SENIOR CITIZENS CLINIC

SUMMARY

The evidence and documentation gathered by this program verifies that a severe health crisis exists in the delivery of health care for older Americans. Thousands of elderly in Minnesota and perhaps millions across America are suffering and often dying because they cannot afford adequate medical care. Their problems must be considered in any discussion of national health insurance plans.

THE PARTIES

Abbott-Northwestern Hospital is a large non-profit hospital in Minneapolis with an excellent reputation for quality care and service to the community. Its Governing Board is made up of many wealthy and prominent citizens from the Twin Cities area.

The Minneapolis Age and Opportunity Center (MAO) under the direction of its Executive Director, Daphne Krause and Governing Board of Senior Citizens, provides the broad range of services to maintain seniors in their own homes and in independence. Services include: counseling, meals-on-wheels, employment, home health-homemaker services and telephone reassurance. Funding comes from Model Cities and from Title III of the Older Americans Act.

Blue Cross-Blue Shield of Minnesota (Robert Johnson, President) is the intermediary for the Medicare program in Minnesota. Blue Cross determines (using Federal guidelines) which Medicare cases are compensable in Minnesota and how much hospitals should be paid for various charges. Blue Cross also sells insurance policies to senior citizens to cover health expenses which Medicare does not cover. Medicare today only covers 40 percent of the average senior's health bills.

The Bureau of Health Insurance, Thomas Tierney, Director, located in the Social Security Administration is in charge of the Administration of the Medicare program. BHI issues guidelines to the intermediaries (Blue Cross and other insurance carriers in various States) telling them how to administer Medicare claims.

CHRONOLOGY

1. In November of 1973 Abbott and MAO opened a free clinic—free in the sense that they advertised for seniors with incomes below $4,500 ($5,500 for couples) Medicare would be accepted as full and final payment for services rendered in the clinic.

Specifically, Abbott and MAO offered without charge:

Health care in the outpatient clinic
Free transportation to and from the clinic
Counseling
All necessary home care, homemakers services, meals, etc.
The first 3 pints of blood (which Medicare will not pay for)

In addition:

Prescription drugs are provided at the hospital's cost

2. The response was overwhelming. In three months over 7,000 people registered with MAO for the services of the clinic. Patients included former school teachers, former lawyers, former physicians, insurance company presidents, all of whom had exhausted their resources and who had neglected seeking the care they needed because of the expense, i.e., Medicare premiums, coinsurance and deductibles. *N.B.* It is to be restated that Medicare today pays for only 40 percent of the average senior's health bill.

3. Some 85 percent of the more than 3,000 older Americans seen in the clinic to date were in need of immediate medical attention. The hospital did more EKGs in a *week* than they had done in the previous *year*. An unusual number of the patients seen in the clinic required immediate hospitalization. On any given day about 40 clinic patients are hospitalized.

4. Abbott has been hard pressed to find enough doctors and nurses to take care of patients. No one expected this tremendous outpouring of elderly. Nor could anyone imagine the pathology. A random sample of a dozen patients disclosed the following problems:

A man admitted for heart surgery
A woman with imminent gangerine of both feet
A man suffering from rectal mass, anemia and rectal blood
A woman who needed surgery to replace her left hip (she could not walk ¼ block without pain)
A man in need of stomach surgery
A man with congestive heart failure, edema, cateracts, marked tooth decay, and dementia
A woman with incontinence, urinary infection, severe arthritis

A man whose last contact with a physician was when he had his World War I physical

A man who was blacking out because the batteries in his pacemaker needed replacement but who put off having the batteries changed because he was still paying for the installation of the pacemaker three years ago.

5. The Minnesota Medical Society was skeptical of the clinic and attempted to persuade its members not to work at the clinic as heralding the arrival of "socialized medicine." The efforts of Blue Cross to kill the clinic were more overt indicating an obvious conflict of interest as follows below:

A. Blue Cross-Blue Shield in Minnesota and elsewhere offers so-called Medi-Gap policies which pick up what Medicare does not. Because of increases in the premium copayment and deductible and because Medicare each year pays less and less of the average senior's health costs, it is axiomatic that Blue Cross through its Medi-Gap policies must pay more of the bill. In every State of the Union (except Minnesota) such Medi-Gap policy premiums were raised this year, because of the Medicare deductible's increase from $72 to $84 and the increase in Part A coinsurance from $18 to $21.

B. In *Minnesota* premiums were reduced by 50 cents to $1.50 a month and a special open enrollment plan was announced from January 22 through February 22, 1974, so that new enrollees would be accepted *without a health history* (an extraordinary step). (See exhibit I.)

C. Experts in Minnesota testify that the decrease in Medi-Gap premiums offered by Minnesota Blue Cross is directly attributable to the opening and success of the Abbott free clinic. If the clinic accepts Medicare as full and final payment care, there is no need for a Medi-Gap policy and seniors in Minnesota began dropping them by the thousands as they signed up for the free clinic. The consensus in Minnesota is that to stop the exodus to the free clinic and the dropping of Medi-Gap policies, Blue Cross reduced rates and went so far as to declare an open season taking the elderly without health examinations!

D. This effort apparently was not successful in stemming the tide as more and more seniors signed up for the clinic and subsequently dropped their Medi-Gap policies between January and April 1974.

E. But Blue Cross had other leverage it could use on the clinic. Blue Cross is also the Intermediary for the State of Minnesota. Under contract with the Social Security Administration and subject to rough Federal guidelines, Blue Cross determines which Medicare claims are compensable in Minnesota. Present evidence suggests that Blue Cross is deliberately cutting off payment to the clinic. (Please read in detail minutes between Abbott Hospital people and Ms. Sharon Blood of Minnesota Blue Cross who admits the clinic is being singled out—it speaks for itself.) (See exhibit II.)

CONCLUSIONS

1. There is a tremendous unmet health need among senior citizens. Thousands if not millions of senior citizens are going without the care they need because they cannot afford it.

2. The dimensions of the problem are far greater than commonly imagined. It can be seen in hard practical terms that Medicare is not doing the job for senior citizens. To begin with certain important services, eyeglasses, dental care and out-of-hospital prescription drugs are not covered. Secondly, seniors must pay increasing premiums, co-insurance and deductibles as the price for participating in the program and in return are faced with Medicare's constantly shrinking coverage today covering only 40 percent of the average senior's annual health bill.

3. The health problems of most senior citizens can be alleviated if caught in time. Many senior citizens can be maintained in independence through the use of minimum supportive services such as counseling, meals-on-wheels or meal preparation, housekeeping or homemaker assistance. Caught in time, in-home services constitute a very real alternative to institutionalization (nursing home placement) and result in substantial savings to the government.

4. Left untreated, the health problems of seniors will increase; many will die and others will be placed in nursing homes at two or three times the cost to the government of in-home supportive services to maintain them in independence.

[From the Minneapolis Star, Jan. 24, 1974]

EXHIBIT I

ELDERLY WILL GET BREAK ON RATES, BLUE CROSS AND BLUE SHIELD SAY

[By Randy Furst, Minneapolis Star Staff Writer]

Blue Cross and Blue Shield of Minnesota said today that it is reducing rates for persons over 65 enrolled through the company's Medicare supplemental programs.

The reductions, effective on billing dates after March 1, cover 70,000 persons, the company said.

Reductions will range from $1.25 to 50 cents on monthly payments, according to information supplied by the state insurance division of the Minnesota Commerce Department.

One supplemental policy would be reduced to $1.25 from $2.50 a month, and another would be reduced to $5.75 from $6.25 per month, the figures showed.

James W. Keeler, state manager of public relations and advertising for Blue Cross and Blue Shield, said this morning that he did not have information readily available on how much Blue Cross and Blue Shield rates had increased in recent years, before today's announcement of the reductions.

He said however, that supplemental program rates have not risen during the last year.

Keeler said that the reduction was "due to the decrease in the hospital stays and a decrease in the frequency of the use of hospital and medical services which we feel is a tribute to the vigilance of the physicians in the hospitals."

Robert L. Johnson, president of Blue Cross and Blue Shield of Minnesota, said that persons enrolled in the program would be notified of the new rates by the end of the week.

He said that persons enrolled in the Medicare supplemental programs will receive an increase in benefits from Blue Cross and Blue Shield because the company also will cover recently announced increases by the Health, Education and Welfare Department (HEW).

HEW increases rise to $84 from $72 in the initial deductible and to $21 from $18 a day co-insurance for Part A medicare, he said.

Johnson also announced that a special open enrollment program will be conducted from Tuesday to Feb. 22. Johnson said that during that time, "All Minnesotans 65 years or older who are enrolled in Part A and Part B of Medicare and are not presently enrolled in Blue Cross and Blue Shield of Minnesota will be accepted for the new Medicare Plus Program with no health history."

EXHIBIT II

APRIL 11, 1974.

To: George G. Adamovich, George Bonewell, M.D., Daphne Krause, Robert C. Millar.

From: Richard J. Kramer.

Subject: Medicare Rejections of Diagnostic Tests Ordered by Senior Citizens Clinic Physicians.

Attached are the minutes of the meeting held on April 11, 1974 with Ms. Sharon Blood, Supervisor, Medical Review Team, Blue Cross. As reflected in the minutes, Blue Cross is deliberately discriminating against the Clinic because we are perceived as different, and of course, our large volume is troubling them.

After you have had time to review these minutes, I would suggest a conference to discuss our strategy.

Thanks.

ABBOTT-NORTHWESTERN HOSPITAL—MEETING WITH BLUE CROSS—HOSPITAL INTERMEDIARY FOR PART B, MEDICARE, APRIL 11, 1974

MINUTES

Present: Sharon Blood, Supervisor, Medical Review Team, Blue Cross, Dr. Bonewell, Wayne Abell, Ray Daum, Marion Kuehn, Richard Kramer, Kathy Mahoney, Lavetta Pearson and Helen Yates.

The meeting was convened at 8:30 a.m. by Richard Kramer.

Mr. Kramer briefly explained the nature of the clinic patient's entry into the health care continuum and the methodology and reasoning behind the ordering of diagnostic tests by Community Medical Associate physicians. Mr. Kramer indicated that as of January, 1974, the initial intake diagnostic test screening was discontinued, and that no tests were being ordered without the patient first seeing a physician. He added that the physicians were ordering only those tests which they felt were necessary to help them pinpoint the patient's diagnosis and established a treatment plan. This information was communicated to Chet Neise and Ms. Blood in late January. Mr. Kramer stated that Abbott-Northwestern Hospital continued to receive claim rejections for laboratory, x-ray and EKG tests ordered in January, February and March which the physicians deemed to be essential. He explained that the purpose of this meeting was to explore the reasons for these rejections and to develop any procedures necessary which would medically support the necessity for tests ordered and facilitate Blue Cross review under current Medicare regulations.

Ms. Blood indicated that Blue Cross was stunned by the volume of claims and was finding it difficult to determine which claims should be paid. She stated that "it was almost a flip of the coin". Ms. Blood indicated that Blue Cross was attempting to pick out acute problems and reimburse these claims. Blue Cross does not feel that they can pay claims for diagnostic screening for chronic problems.

Mrs. Pearson presented the case of a patient with uncompensated congestive heart failure. She indicated that this patient was acutely ill, yet Blue Cross rejected the total claim. Ms. Blood stated that Blue Cross cannot tell if the diagnosis was made by the doctor prior to or after ordering the tests. Ms. Blood indicated that they needed to know when the patient saw the doctor and what specific laboratory and x-ray tests were ordered. If the diagnosis was made after the test results were reviewed, the claim would be rejected.

Mr. Kramer pointed out that the present Medicare Claim Form does not ask for this kind of information and he inquired if other hospitals were being asked to do this. Ms. Blood stated that this is not a standard procedure, but that Blue Cross was finding it difficult to cope with the volume of M.A.O. claims. Mrs. Kuehn pointed out that this would create a significant expense for the business office and medical records departments.

Dr. Bonewell stated that in his opinion all tests being ordered were very basic for this patient population in 99% of the cases.

Mrs. Pearson presented the case of a patient with chronic obstructive lung disease in which the total claim was rejected. Ms. Blood stated that this patient had no reason to see a doctor since he did not come in with acute symptoms. Ms. Blood agreed with Dr. Bonewell that the tests ordered for this patient were related to the patient's symptoms, but she argued that, in her opinion, the patient would not have sought care if the Clinic did not exist. Dr. Bonewell stated that if he did not order these tests he would risk a malpractice suit.

"Blue Cross Not an HMO"

Ms. Blood pointed out that "Blue Cross was not set up as an HMO" and that "physical exams are verboten" and will not be paid for. Ms. Blood stated that the Clinic has been "singled out because you have opened up your arms and said to everybody come to us—we will take care of your problems". Ms. Blood added that "Medicare cannot maintain (referring to health maintenance) people in a healthy or unhealthy position". Dr. Bonewell suggested that the Clinic was being discriminated against, and Ms. Blood stated that "yes, we are singling you out as well as Mt. Sinai Hospital". Dr. Bonewell stated that, in his opinion, asking the Clinic to justify each claim with additional information was discriminatory, Ms. Blood agreed.

Mrs. Yates asked if recording symptoms versus diagnosis on the Medicare form and specifying each type of laboratory or x-ray test would be helpful to Blue Cross in their review process. Ms. Blood seemed to think that this would be helpful.

Mrs. Pearson presented the case of a patient seen in the Emergency Room presenting symptoms of blood in the stools with previous history of heart attacks. A barium enema was ordered and the claim was rejected. Ms. Blood indicated that her office cannot tell from the Medicare form what type of visit

the patient was seen for. Ms. Blood stated it is not sufficient justification for claim payment purposes for the doctor to relate a test to a symptom he finds after he examines the patient. For example, Medicare will not pay for laboratory tests ordered as a result of the first Clinic visit unless the patient is hospitalized that day.

Ms. Blood stated that "we (Blue Cross) are being discriminatory against the Clinic because of the way you are set-up". Dr. Bonewell suggested that Blue Cross was not even perusing the claims, just totally rejecting them. Ms. Blood indicated that she has instructed her employees to look for an emergency room charge as a basis for possible payment and that any claim which shows a combination of laboratory, x-ray and EKG tests is to be rejected.

Mr. Kramer suggested that in his opinion these matters needed to be discussed at the Social Security Administration policy making level and that Ms. Blood was acting according to her supervisor's instructions. Mr. Kramer asked Ms. Blood if there was anything the Clinic could do in the interim to make the Blue Cross review easier and avoid resubmission of claims by the Clinic. Ms. Blood indicated that Mrs. Yates' suggestion of listing presenting symptoms and specific test breakouts would be helpful. Mrs. Kuehn and Mr. Abell suggested that the existing Clinic Medicare Billing Information Form could be revised to meet these needs.

Ms. Blood initially suggested bypassing the regional Medicare office with our problem and making contact with Mr. Tierney of HEW. She later indicated that she thought it would be best to work through the local office and the normal chain-of-command. Ms. Blood asked for additional information about the Clinic to give to her supervisor, and Mr. Kramer indicated that it would be furnished.

The meeting was adjourned at 10:00 A.M.

Respectfully submitted,

RICHARD J. KRAMER, *Recorder.*

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