par with Philadelphia and in Rhode Island, coastal town of Narragansett, there are 8 dirty days, three times as many as there were in Providence, and even upstate Vermont have not escaped the dirty air this year.

And it is showing impact into areas and communities and into the lives of children and families in that we need to make sure that the legislation that my colleague is offering, is co-sponsored by other Members and that Members are signing this Dear Colleague, that it is going to the EPA and to the administration to do their job and to recognize that they still have the authority in regards to this action as it pertains to the 1-hour rule that was not overruled by the court and to continue to require that these States be brought into conformance and that Maine not end up being the tail pipe for these kinds of inefficient, harmful pollutional industries that have been going on throughout the Midwest in particularly.

Mr. Speaker, I yield to my colleague, the gentleman from Maine (Mr. ALLEN).

Mr. ALLEN. Mr. Speaker, we have been talking so much about the Northeast because, after all, as my colleagues know, the wind, as I say, does blow west to east, so the Northeast is impacted. But it is worth pointing out, I think, that in many local areas where these grandfathered plants are in existence the local smog, the ozone, is a real health concern, and that can be true in the Midwest, in the South and in the West itself.

Mr. Speaker, the reason for that is that many of these plants have been allowed to engage in what is called the ''cap-and-trade approach''; that is, they can effectively buy clean air credits without cleaning up their own plant, and they still get by and meet the existing standards. What I am trying to say in this legislation is that with respect to nitrogen oxides and sulfur dioxides, which produce ozone, smog and acid rain, there would not be any provision for capping and trading; so the result will be that many of the dirtiest plants scattered in the Midwest, in the South and the West itself, will have to be cleaned up. That will be an enormous advantage to people who live in those local areas.

And so this is not just a Northeastern bill; this is a national bill. And I trust that many Members from around the country will be willing to support it, and I thank the gentleman for yielding.

Mr. BALDACCI. Mr. Speaker, I thank the gentleman for pointing that out because pollution is a national issue, requires a national solution, and its impact and benefits will be on a national basis. And to be able to make that point, I was just reading where the national parks, the millions of people that visit these particular parks that have been impacted by the ozone transport and increased smog and pollution and health risk, not just Acadia National Park in Maine, but Cape Cod, the Great Smoky National Park, Shenandoah National Park, Indiana's National Lakeshore Recreation Area, many other of these national parks and outdoor places where 2.7 million, 4.9 million, 9.3 million, a million and a half people, each one has been able to go to those facilities to enjoy the outdoors and that quality of life.

And Tennessee, the cradle of blues, rock and roll, and country music makes tourists in the Smoky Mountains sing a sad song about the smog they thought they left behind; in historic Virginia, George Washington's Mt. Vernon home as well as Colonial Williamsburg are suffering with pollution levels as great as our Nation's capital. Other Southern tourist destinations did not fare much better, Shenandoah's National Park and even remote Mt. Mitchell, and no relation I do not assume, but Mt. Mitchell in North Carolina have had unhealthy levels of ozone.

So those are within the Southeast, within the West. They are talking about Salt Lake City, surrounded by mountains, has been trapped in pollution for 3 days this year. Houston, second only to L.A. in population in the West, also home to chemical and refining industries. It is not geared just to the Northeast, it is the Southeast, it is the West, it is the Midwest, the Midwest home to small town U.S.A., but in addition to agriculture areas is dotted with major industrial cities. Many folks in the upper Midwest spend their spare time recreating in these areas.

So it is reinforcing my colleague's point about the national impact of this legislation, and I yield back to my colleague from Maine.

Mr. ALLEN. As we are having this conversation, I was looking at a recent report, and there is something here that is directly on point. I thought I would mention it.

Within the Ohio River Valley, this report says, there is a large and persistent area of high ozone during the summer months compared to air in other parts of the country, and in this region winds intermingle ozone pollution from different power plant fumes, as well as from other sources. Somewhat surprisingly, people living in the Ohio River Valley are exposed to higher average smog levels over a more prolonged period of time than people living in Chicago or Boston, and that goes back to what we have been talking about, that this is not just about the Northeast. If the smog in the Ohio River Valley, where a number of these plants are located is higher on average than the smog in Boston and Chicago, it is pretty clear we have got a national problem and it needs a national solution.

Mr. BALDACCI. Mr. Speaker, if I can, just to reinforce the impacts of what we are talking about, children are most at risk. Children breathe even more air per pound of body weight than adults because children's respiratory systems are still developing; they are more susceptible than adults to environmental threats. Ground ozone is a summertime problem because of the heat and the combination of the pollution creating this, and children are outside playing and exercising during the summer months. Asthma is a growing threat to children. Children make up 25 percent of the population, and 40 percent of the cases of asthma are here. We are talking about 14 Americans dying every day from asthma, a rate three times greater than just 20 years ago.

So we are talking about the pollution impacts, the impacts to individuals and communities. And I want to thank my colleague from Maine for introducing his comprehensive legislation and encouraging Members to sign onto it, and signing onto the Dear Colleague and making sure that the administration does its work, the courts do their work and that we do our work.

TEACHING HOSPITALS IMPACTED AS RESULT OF PASSAGE OF THE BALANCED BUDGET ACT

The SPEAKER pro tempore (Mr. COOKSEY). Under the Speaker's announced policy of January 6, 1999, the gentleman from Illinois (Mr. DAVIS) is recognized for 60 minutes.

Mr. DAVIS of Illinois. Mr. Speaker, during the last several months we have had a tremendous amount of discussion about managed care, patients' bill of rights, different kinds of indicators of disease and problems with our health care delivery system, trying to find a way and trying to find solutions, answers, to many of these problems. Group of us come this afternoon because we want to talk about another problem, and that is a problem facing the hospitals in the State of Illinois and especially facing tertiary care teaching hospitals as a result of our passage of the Balanced Budget Act.

Health care, as all of us would agree, is one of the essential elements of a great society, and unless people have access, have the ability, unless people have the assurances of knowing that they can find the care that they need in times of stress and difficulty and in times of physical pain and disability, then that society is missing something.

As a member of the Illinois delegation, I am going to share some concerns about the fate of Illinois' teaching hospitals and academic medical centers unless we get some form of relief from reimbursement cuts authorized in the 1997 Balanced Budget Act.

While we all recognize that cost containment, trying to manage the cost of health care, is important, all of us recognize the concerns that have been expressed over the years about unregulated, unbridled, unchecked cost overrunning our ability to pay; and so while we recognize that certain sacrifices must be made in order to achieve Balanced Budget Act objectives, we strongly believe that the unintended consequences of the Balanced

Budget Act threaten the viability of these valuable health care resources.

As envisioned, the Balanced Budget Act was intended to cut $104 billion from Medicare reimbursement to hospitals.

□ 1500

However, the Balanced Budget Act, if implemented as enacted, will result in nearly $200 billion in reductions.

Now, the people of Illinois have come to expect, and they have every right to do so, the high quality medical care delivered by our teaching hospitals and academic medical centers. The benefits derived by residents of every region of our State are incalculable. These teaching hospitals and academic medical centers are the primary providers of complex medical care and high risk specialty services, such as trauma care, burn care, organ transplants and prenatal care to all patients, regardless of their ability to pay. In fact, the 65 tertiary care teaching hospitals in Illinois provide approximately 63 percent of all hospital charity care in the state.

Aggressive Balanced Budget Act cuts are jeopardizing their ability to fulfill their vital mission of maintaining state-of-the-art medical care and technology, providing quality learning and research environments, and serving as a safety net for those unable to pay.

Not only do these institutions enhance our health and physical well-being, they are also some of our largest employers and consumers. As a matter of fact, they are an integral part of our overall economy. In total, our Illinois teaching hospitals and academic medical centers employ more than 56,000 of our constituents and add almost $3 billion to the State's economy in salaries and benefits alone. Yet, despite the great benefits that Illinois residents derive from our teaching hospitals and academic medical centers, these institutions suffer disproportionately under the Balanced Budget Act.

In total, Illinois teaching hospitals face 5-year reductions of more than $2.5 billion. I will say that again. In total, Illinois teaching hospitals face 5-year reductions of more than $2.5 billion. Consequently, while teaching facilities comprise 27 percent of Illinois hospitals, they will bear the brunt of 59 percent of the Balanced Budget Act reductions. These cuts are compounded by increasing fiscal pressures from managed care companies and inadequate Medicaid reimbursements on the State level. We believe that we must act now, that we really cannot wait.

I represent a district that has 22 hospitals in it. I have four academic medical centers, four of the best in the Nation, in my district. Not only do they provide greatly needed care, but they are also the primary trainers of medical personnel, not only for Illinois, but all over America. I have three Veterans Administration hospitals in my district that are linked to these medical schools.

So not only are we looking at the provision of greatly needed care, but we are also looking at the overall economic impact on a community if the individuals cannot work, if they have no place to go. Then, obviously, the status of health for the community worsens, worsens, and worsens.

Also with me this afternoon, one that I know is greatly interested in this problem and this issue and has concerns not only about the ability of hospitals to serve but the ability of our society to function as it is intended to do, it pleases me to yield to the gentlewoman from the 9th District in the State of Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. Mr. Speaker, I want to thank the gentleman from Illinois for organizing this special order tonight and for yielding time. His commitment to providing quality health care in Illinois and across the Nation is unparalleled.

There is probably not a Member in this House that is not committed to and has not talked about protecting Medicare, but that means more than just the benefits under the Medicare program. That means that we have a strong and vibrant delivery system in place. That is what we need, one that is available to meet the needs of Medicare beneficiaries.

Unfortunately, the payment cuts required under the Balanced Budget Act threaten that delivery system. Inadequate payment levels are jeopardizing quality care at nursing homes, in hospices, for home care services, and the subject of tonight's special order, hospitals.

Now, my mother-in-law in Shreveport, Louisiana, Adelaide Creamer, was director of volunteer services at the large university hospital there; and she knows, as good as volunteers are, this is one issue where we are going to need far more than that in order to meet the needs of our Medicare patients.

We need to understand as policymakers and as consumers that payment cuts and inadequate reimbursement levels are patient issues. Patients will suffer if we do not act now to correct the problems created by the Balanced Budget Act.

The Balanced Budget Act, when it was passed, was supposed to cut hospital rates by $53 billion, but the actual cuts are now estimated to be $71 billion. As the gentleman from Illinois has said, cuts in Illinois would be close to $3 billion, and, in my Congressional District alone, the cuts could approach $270 million over 5 years. Because the size of the cuts grows every year, the longer we wait to correct this problem, the greater the impact on patients and healthcare quality.

I want to emphasize that we are not talking here about slowing the growth rate in hospital payments in the coming years. Without a correction in the Balanced Budget Act provision, Illinois hospitals will face actual reductions below existing payment levels. That is why the Honorable John Stroger, President of the Cook County Board, and Robert Maldonado, County Commissioner, and many of the members of the Cook County board, introduced and passed a resolution that calls on the President and the Members of the 106th Congress to refrain from enacting additional Medicare reductions in addition to those contained in the Balanced Budget Act of 1997, and to use at least a portion of the Federal budget surplus to address the negative impact caused by these reductions.

Obviously, as the cost of healthcare rises, cuts of these magnitudes will mean that hospitals will face horrible decisions, whether to cut back on staffing, turn away patients, shut down services such as trauma care, delay elective surgery, impose cutbacks on clinics and outpatient services.

In February, I wrote to President Clinton endorsing his proposal to use 15 percent of the budget surplus for Medicare and encouraging him to place a moratorium on any further BBA, Balanced Budget Act, payment reductions. Recognizing the problems being created already by the Balanced Budget Act, we simply cannot allow it to continue in place.

We need to take additional steps as well. I particularly am concerned about the impact of cuts on disproportionate share hospitals, hospitals that serve a large number of uninsured and underinsured patients.

We have heard a lot this week from the Republican leadership expressing their concern about the 44 million uninsured Americans. Disproportionate share hospitals care for those uninsured persons. They are the only source of care for many children and adults.

According to the Illinois Hospital Association, 30 percent of these disproportionate share hospitals had negative margins before the Balanced Budget Act was enacted. By 2002, if we do not act to stop further reductions, two out of every three of these hospitals serving low-income people will have negative margins.

In Illinois, these DSH hospitals, is what we call them, will lose $1.7 billion. $1.7 billion. These cuts are simply not sustainable. As the number of uninsured rises, DSH providers should be getting more resources, not suffer the cutbacks required under the balanced budget amendment.

Patients who rely on teaching hospitals would also suffer. The $1.1 billion in projected cuts to Illinois teaching hospitals threaten their ability to train medical professionals and serve patients.

Tertiary teaching hospitals in Illinois provide over half of all charity care in the State, even though they represent only 13 percent of hospitals. That care too would be threatened. Finally, teaching hospitals provide critical specialty services, trauma centers, organ transplants, specialized AIDS care, and other critical services.

Teaching hospitals are pioneers in training medical professionals and providing complex and innovative medical

technologies to patients. We should make it a priority to ensure that they have adequate resources to continue to do so. As less and less services are performed on an inpatient basis and more and more in hospital outpatient departments, we need to take action to stop drastic cuts for outpatient services.

Finally, I hope that we will act to repeal the annual $1,500 per patient cap on rehabilitation therapy payments. This arbitrary cap is preventing patients from getting adequate care to maintain, restore, and improve their functioning. We need to protect and increase payments to disproportionate share hospitals and payments for teaching hospitals. We need to protect against drastic cuts in outpatient hospital care. If we fail to do so, the real victims will not be the providers, they will be the patients who rely on their hospitals for quality, compassionate, and timely care.

Again, I thank the gentleman for the time.

Mr. DAVIS of Illinois. Let me thank the gentlewoman from Illinois for her comments. As I was listening, I was just sure that not only are the people of the 9th District in Illinois pleased that you are here working on their behalf, but citizens from all over the State of Illinois are pleased to know that they have you as a Member of Congress fighting for their rights and for their communities. So I thank you so very much.

The gentlewoman that I would like to next yield time to is not from the State of Illinois, but any time that she would want to come she is always welcome, and especially would she be welcome in the 7th District. But I would like to yield to the gentlewoman from the State of North Carolina (Mrs. CLAYTON).

Mrs. CLAYTON. Mr. Speaker, I thank the gentleman for his time and gracious comments, and I appreciate him allowing me to say a few words during his designated special order on the impact of the 1997 budget on hospitals as it relates to hospitals, particularly in urban areas.

I come from rural North Carolina. I am here to talk about another issue, which I will do later, but I could not pass up the opportunity of reaffirming how important the subject you are talking about is, how the 1997 Balanced Budget Act affects hospitals, and to also share with you that the implication is even more severe for those of us who live in rural America.

Just think that if indeed you think about the delivery system or the infrastructure for health care being at peril in urban areas, think of rural areas of having already a severe shortage of providers and institutions and heavily dependent on Medicare reimbursement and Medicaid reimbursement, and, therefore, having private insurance to pay for most of their care is not a part of the equation in supporting rural hospitals or nursing homes or home health services or hospice services. They are heavily dependent on the participation of the Federal budget.

So your raising this issue for us helps us to join with you from rural America to say that this is a nationwide project, it is a nationwide problem. It is a challenge for those of us who live in rural America, because we serve a disproportionate number of senior citizens who are very much dependent on Medicare.

The teaching hospital that is in my district, for their interns and their fellows, it is supported in the main by the Medicare payments that are made to the individual institution.

□ 1515

We talk about DSH. Most of our hospitals are actually disproportionately hospitals in rural areas so we are on the verge of losing hospitals in our area if, indeed, we pursue with this gradual sliding below to the lowest common denominator, Balanced Budget Act projection, given just what the last speaker spoke of. Actually we have exceeded those projections where the intent was to have 53 percent.

Now we have exceeded those. So just think, that means we are going to have to make decisions about cutting outpatient, making decisions about cutting AIDS programs, of all of those extra programs that hospitals were beginning to equip themselves for, so they would not have to keep patients in their hospitals in beds. They had outpatient, they had therapy, they had rehabilitation programs. All of those are threatened under the 1997 Balanced Budget Act.

It is not the act itself. It is the implementation. So we really do need to do two things. There needs to be two tracks. We need to make a case to the administration in the finance mechanism that they need to adjust where they have authority to adjust so they can make that relief that hospitals need right now.

Secondly, we need to make some amendments in our budgetary process to allow for us to not have the year 2000 as structured as we had proposed in 1997.

I thank the gentleman for allowing me to participate and just would say finally that rural hospitals also are appreciative of the efforts of the gentleman to raise this issue for Members of Congress so that we can take the appropriate action.

Mr. DAVIS of Illinois. Mr. Speaker, let me just thank the gentlewoman and commend the gentlewoman again for the tremendous advocacy that she displays consistently on the part of rural America, and especially as she crusades right now to try and find relief for that part of North Carolina and for all of those thousands and thousands of people who have been uprooted by recent Hurricane Floyd.

Certainly, our hopes, our prayers, and our thoughts are with the gentlewoman and all of the people in North Carolina as they try to work their way out of this disaster.

Mr. RUSH. Mr. Speaker, will the gentleman yield?

Mr. DAVIS of Illinois. I yield to the gentleman from Illinois, who represents a district that certainly has one of the most outstanding hospitals and academic medical centers in the Nation in it, the University of Chicago.

Mr. RUSH. Mr. Speaker, I want to thank the gentleman from Illinois (Mr. DAVIS), Congressman from the 7th Congressional District, for holding this special order. This special order is important to the hospitals in my district, the hospitals in urban America and, as the previous speaker indicated, the hospitals in rural America.

I want to say to my colleague from the 7th Congressional District that, again, he is on point. We served in the Chicago city council together. He was a leader on health care issues in the city council. He was a leader on health care issues when he was a member of the Cook County Board of Commissioners and now in the Congress he is a leader on health care issues, and I want to applaud him for his leadership and again thank him for holding this important special order.

To the gentlewoman from North Carolina (Mrs. CLAYTON), I want to join with my colleague from the 7th Congressional District in indicating my support for her, my support for those distressed constituents in her district, those individuals who are experiencing hardship now because of Hurricane Floyd. I want her to know that any time she wants to visit her son, who is a constituent of mine in the 1st Congressional District, she certainly can come in; and we will roll out the red carpet for her, as we have done in the past.

The Balanced Budget Act, Mr. Speaker, is causing real pain for hospitals, for patients, and the communities that they serve. The BBA has produced an unintended financial burden on Chicago teaching hospitals, on rural hospitals, on skilled nursing facilities, and on home health providers. The issue is important, to me and to others, because Illinois ranks fifth in the Nation in the number of teaching hospitals.

Teaching hospitals not only provide training to our Nation's future doctors but they also provide uncompensated care to underserved communities. In my State, the State of Illinois, these teaching hospitals provide 59 percent of the State's charity care. Additionally, in teaching hospitals in Illinois and in academic medical centers in Illinois, there are at least 80,000 Illinoisans statewide who are employed by these hospitals.

As a matter of fact, Illinois teaching hospitals and academic medical centers are one of Illinois' largest employers. They add more than $3 billion in salaries and benefits to the Illinois economy.

Because of these BBA cuts, these hospitals will lose $1.678 billion between

fiscal year 1998 and fiscal year 2002. $1.678 billion the hospitals in Illinois will lose between fiscal year 1998 and fiscal year 2002. These cuts would be atrocious, these cuts will undeniably deny many low-income patients adequate and much-needed health care.

This year this Congress passed a budget resolution that would have allowed for $792 billion in tax breaks, mostly to millionaires and billionaires, those who are living the good life, but not one red cent to fix the damage to Medicare from the BBA.

Ironically, today in this Congress we are seeing that Members who voted for the BBA 2 years ago, they are now switching. They are now reversing their positions. They are now supportive of fixes to Medicare.

Mr. Speaker, the Members on both sides of the aisle, this Congress, the Republicans particularly, this Congress must fess up and admit that it made a mistake; and it must do the right thing by funding for substantial increases in Medicare reimbursements.

Mr. DAVIS of Illinois. Mr. Speaker, let me just thank the gentleman from Illinois (Mr. RUSH) for the comments that he has made because what he has said actually is the same thing that I am hearing from constituents of mine each and every day.

In my hand and in my office are actually thousands of cards that I have received from constituents of my district asking that we provide for them some relief. They are very active people who understand what is going on, who recognize when they hurt that they need to cry, and who recognize that if they do not cry chances are nobody will even know that they are hurting.

I can say that the people of the 7th District are crying. They are crying out for relief from the Balanced Budget Act. They are crying out to make sure that their hospitals, that their health centers, that their skilled nursing homes, can continue to exist and provide for them the greatly needed services that they so richly and rightly deserve.

So I thank the gentleman for being where the people are, and I appreciate his comments.

Not only, though, are we saying it, I mean the Members of Congress are saying it, but also I am looking at editorials, and I would put these entered into the RECORD at this point, Mr. Speaker.

[From the Peoria Star Journal, Aug. 31, 1999]

MEDICARE REDUCTIONS THREATENING HOSPITALS

If these are the good years, then why are hospitals administrators so blue? The answer is that they're seeing red.

Medicare cuts being implemented now are ''the most serious reductions in the history of the program,'' says Ken Robbins, president of the Illinois Hospitals and Health Systems Association.

Hospitals operating on a slim margin, or dependent on Medicare for almost all of their revenues, will close, he says. Those which stay in business will cut staff, eliminate unprofitable programs and increase prices charged paying patients, forcing insurance rates up.

Teaching hospitals, which will lose more assistance than most, will cut residency slots. That will threaten medical specialities and charitable care, which depends heavily on resident physicians. Already OSF St. Francis has trimmed seven positions and is considering eliminating an entire residency program. In the 26 years he's been looking Robbins says he's never seen a more critical threat.

It seems peculiar that hospitals are ringing this alarm as congressman fan out across the land to tell of a federal treasury overstuffed with surplus dollar bills. The timing is not accidental.

The federal surplus owes its existence not just to a booming economy but to the domestic spending cuts mandated by the Balanced Budget Act of 1997. About half of them will come from Medicare and Medicaid. The American Hospital Association anticipates that by 2002, hospitals will lose $71 billion, a little more than one of every 10 Medicare dollars they take in.

OSF St. Francis figures it will give up $27.6 million; Methodist, $22.6 million; Proctor, $18.2 million. To appreciate the size of the losses, and the steps necessary to compensate, consider that Methodist and Proctor derive 50 percent of their income from Medicare, while St. Francis gets 40 percent. By the end of 2002, Robbins says Illinois hospitals will be treating more Medicare-dependent patients for fewer inflation-factored dollars than they get now. He says everybody who needs hospital care will feel the effects.

The hospital association wants legislation that will restore $25 billion, a little more than a third of what hospitals lost. To get the money, it will have to fight off those who would spend the surplus on tax cuts and those who would pay down the federal debt.

Members of both camps say they want to make sure the anticipated surplus isn't used to increase spending. That is an understandable goal but an inaccurate description of the alternative. The third choice in the surplus arguments is not whether to expand federal programs with the extra money but whether to maintain the present level of service.

Permitting spending to grow at the rate of inflation would cost nearly $750 billion, or three-fourths of the predicted 10-year non-Social Security surplus. Assuming that defense spending will not be reduced, the Balanced Budget Act will require domestic spending cuts of about 20 percent over five years. If Congress boosts military spending, as it has indicated it would like to do, then bigger reductions in domestic spending will be necessary.

The hospital lobbyists would seem to be at vanguard of those who will feel the pinch. Earlier this month Peoria officials said they anticipated a 10 percent cut in Community Development Block Grant funds for neighborhood-based programs. Housing and Urban Development Secretary Andrew Cuomo warned last week of budget cuts that would leave 156,000 people without affordable housing. The nation's parkland preservation program is due to be reduced to one-tenth of its 1978 level. Congress has put out feelers about taking back from the states $4.2 billion in welfare reform money.

Cuts of this magnitude may have made sense when the nation was battling to control deficit spending and the threats it posed. The case for them is not as strong now that it's been declared the post-deficit era on Capitol Hill.

Certainly maintaining Head Start participation and national park dollars and environmental enforcement at present levels, rather than slashing them, deserves an equal platform with tax cuts and debt reduction as decisions are made. So do the hospitals' concerns.

It is particularly irksome that the facts of the issue have been so poorly laid out and that the budget cuts which lie ahead have claimed so small a stage in the national debate. Perhaps the hospital lobbyists will help.

[From the St. Louis Post-Dispatch, August 4, 1999]

WHEN HOSPITALS GET SICK

The nation's teaching hospitals, the backbone of the country's health care system, are getting sick. Squeezed on one side by managed care's demand for lower costs and shorter stays and on the other by federal cuts in Medicare reimbursements, the average teaching hospital will have lost $43 million between 1997 and 2002. That will leave nearly 40 percent of the facilities operating in the red.

Similar dire figures are projected for facilities here. By the end of this year, St. Louis-area teaching hospitals will have seen their revenues reduced by $70 million. The reduction for all the state's teaching hospitals will be about $126 million. By 2002, the figure will have climbed to over $100 million in St. Louis and $214 million for Missouri. Barnes-Jewish Hospital has gone from generating $30 million a year to just $4 million this year.

Those figures are much more than just numbers on a balance sheet. Teaching hospitals, particularly in St. Louis and Missouri, are unique, vital cogs in the health care network. Though they represent only 4 percent of all of the nation's hospitals, they treat 44 percent of the uninsured patients. Meanwhile, they provide expensive, highly specialized programs, such as the organ transplant, bone marrow transplant and trauma programs operating at St. Louis University Hospital and Barnes-Jewish Hospital.

In St. Louis and Missouri, this continued financial hemorrhaging could hurt the local economy. Barnes-Jewish Hospital, with over 8,000 employees, is the largest private employer in the city of St. Louis. Its network, BJC Health System, is Missouri's single largest private employer.

Sen Daniel Patrick Moynihan, D–N.Y., and Rep. Charles Rangel, D–New York, have an answer for the current mess. Mr. Moynihan has introduced a bill to freeze the reductions in Medicare reimbursements for the next two years. The New York Democrats have proposed the establishment of a Medical Education Trust Fund that would be financed by a 1.5 percent assessment on private health insurance premiums and funding from Medicare and Medicaid.

Congress' desire to rein in rising medical costs is commendable, but the 1997 Balanced Budget Act, which cut the Medicare reimbursements for teaching hospitals, produced serious unintended consequences. The nation must not sacrifice the great institution of the teaching hospital to the budgetary scalpel.

[From the Chicago Tribune, July 9, 1999]

UIC TO CUT HOSPITAL JOBS, SEEK MERGER

(By Bruce Jaspen)

In a rare move that highlights the deepening financial crisis of one of the city's biggest teaching hospitals, the University of Illinois said Thursday it will turn over management of its West Side academic medical center to a Florida consulting firm.

At the same time, the university reassigned the hospital's director, announced that more than 10 percent of the hospital's employees will lose their jobs and said it will seek a merger with another health-care firm.

The dire measure for the University of Illinois at Chicago Medical Center were recommended by The Hunter Group of St. Petersburg, Fla., in the wake of millions of dollars in losses, blamed in large part on drastic reductions in Medicare spending growth as a result of the Balanced Budget Act of 1997.

As part of the government's effort to slow the growth in spending for Medicare, the federal health insurance for the disabled and the booming elderly population, the Balanced Budget Act is taking $33.5 million in projected revenue from the UIC's budget over a five-year period, and thus far has contributed to an $8 million deficit in the hospital's second quarter. As recently as 1997, UIC had income of $6.1 million on a budget of nearly $300 million.

UIC has also been vulnerable to an intensely competitive health-care marketplace in Chicago, where one in three hospital beds remains empty and managed-care companies and developments in science are keeping patients out of the hospital.

''We are struggling with making ends meet,'' said Dieter Haussmann, vice chancellor for health services at UIC. ''Unless things change, you will see fewer teaching hospitals in the next decade.''

Like all academic medical centers, UIC is particularly vulnerable to managed care, which emphasizes low-cost outpatient care.

Contracts with teaching hospitals are less attractive to managed-care insurers because the costs of training the nation's future doctors and conducting cutting-edge research typically make services at teaching hospitals 20 to 25 percent higher than at community hospitals.

To keep the UIC's teaching mission of educating doctors viable, The Hunter Group will begin looking for potential partners, possibly leading to a merger or sale to one of any number of possible buyers. Haussmann speculated about one scenario involving the UIC forming some partnership with Rush-Presbyterian-St. Luke's Medical Center or Cook County Hospital, both within a block of the UIC on Chicago's West Side.

''Without some sort of partnership, we are going to have serious difficulties being viable,'' Haussmann said.

Rush executives Thursday seemed open to the idea. ''The University of Illinois is a major institution within the Illinois Medical Center District, and therefore it would be logical for Rush and Cook County to pursue mutually beneficial discussions with the University of Illinois,'' said Rush's senior vice president, Avery Miller.

UIC officials, however, said they would be exploring all options.

''Anything is possible,'' Haussmann said. ''We won't leave any stones unturned from the outset.''

Thursday's decision by the university's board of trustees follows a 14-week study by the Hunter Group, which was paid $1.2 million for its work and will now manage the hospital for $140,000 a month over a period officials expect will be less than a year.

Sidney Mitchell, the hospital's executive director for the last several years, will be reassigned for the time being within the university, Haussmann said. Mitchell was unavailable Thursday for comment.

About 275 of the hospital's 2,600 full-time employees will lose their jobs as part of The Hunter Group's recommendations, but it remains unclear exactly when the cuts will take effect and who will be affected.

Officials hope most of those employees, mainly clerical workers and support staff, will be able to find jobs within the university system, but negotiations on those positions will also take place with some unions.

Earlier this year, the UJC implemented a hiring freeze and eliminated 250 positions, and most of those workers were placed elsewhere, university officials said.

Meanwhile, the proposed changes will also mean a different employment arrangement for more than 300 physicians who are either full- or part-time faculty at the University of Illinois at Chicago College of Medicine and do clinical work at the hospital. They will become more independent, with employment contracts, much like doctors at other academic medical centers where the physicians work for affiliated practices.

Thus, doctors will be forced to build up a base of patients and referrals for the hospital rather than relying largely on the hospital's contracts with insurance companies.

''The idea that the board is looking at is, can these physicians take on more responsibility for their actions?'' said David Hunter, chief executive of The Hunter Group, which will officially take over management sometime next month, once its contract is made final. ''Can physicians take more control over their lives and their practice, and therefore be more productive?''

Physicians appeared to support the changes. ''I'm very positive, and I believe the physicians will be, too,'' said Dr. Gerald Moss, a surgeon and dean of the medical school. ''We believe with these changes the hospital will return to profitability.''

The hospital is also going to streamline billing and collection systems and reduce supply expenses, aiming to save more than $6 million by 2002.

UIC ANNOUNCES CHANGES

University of Illinois at Chicago Medical Center said Thursday it will implement changes for improving hospital operations.

Major recommendations include: Reduce staffing by about 275; Implement supply expense reduction program; Streamline patient registration, billing and collection systems; and Seek a merger or sale.

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[From Crain's Chicago Business, June 21, 1999]

DEEP MEDICARE CUTS DRAW BLOOD AT TEACHING HOSPITALS—TOP MED CENTERS TAKE LARGEST HIT; SURVIVAL OF FITTEST

(By Meera Somasundaram)

Chicago's academic medical centers, known for treating the most challenging cases and training the nation's top doctors, are facing some tough medicine of their own.

Already struggling with pressures from managed care, rising drug costs and a surplus of local hospital capacity, they now are bracing for one of the sharpest cutbacks ever in Medicare payments to hospitals.

And the prognosis isn't good. Some top hospitals are already in the red. Others have seen operating income fall sharply. The most pessimistic observers question whether, long term, the region can support all of its high-end medical centers.

In Chicago, which has an unusually high concentration of such facilities—five major academic medical centers and seven medical schools—the effects of the statewide $2.5-billion retrenchment will be staggering: The five academic medical centers together will lose about $350 million over five years.

Two of the five—University of Illinois at Chicago Medical Center and Rush-Presbyterian-St. Luke's Medical Center—already are feeling the pinch, having reported operating losses in fiscal 1998.

Two that were in the black—Northwestern Memorial Hospital and University of Chicago Hospitals—reported sharp downturns from 1997. Loyola University Medical Center posted operating income after a loss in 1997.

''Clearly, we are in for some difficult times for academic medical centers over the next few years,'' says health care consultant David Anderson of Health Care Futures L.P. in Itasca.

The downward spiral is expected to worsen over the next few years because the cuts—mandated under the Balanced Budget Act of 1997 and phased in from fiscal 1998 to fiscal 2002—widen each year. Some of the current losses have been offset by a robust stock market, which has helped hospitals stay in the black. But that can't continue forever.

HOW MUCH THEY'LL LOSE

Medicare payments are the lifeblood of many teaching hospitals—accounting for 20% to 40% of total revenues.

In addition to receiving payments from Medicare for treating elderly patients, the hospitals also are paid through Medicare for training physicians in residency programs. The larger a hospital's Medicare population and the larger its residency program, the larger its Medicare payment.

Rush-Presbyterian and the University of Chicago Hospitals will lose the most because of their greater dependence on public aid and larger residency programs: Rush will see $104 million in cuts over five years, and U of C will lose $95 million.

As for the other three. Northwestern Memorial will lost $65 million; Loyola, about $50 million, and UIC, $33.5 million, according to Ralph W. Muller, president and CEO of U of C Hospitals and chairman-elect of the Assn. of American Medical Colleges, which is lobbying Congress to restore the cuts.

The fallout from the cuts could drastically change the hospital landscape in Chicago.

The Illinois Hospital and Health-Systems Assn. (IHAA) has predicted that some smaller area hospitals will be forced to close. Others will turn to layoffs, cutbacks in programs or consolidation. In addition, the loss of funds could put a squeeze on research programs and bolster unionization efforts among physicians and nurses seeking job security amid the turmoil.

Notes Jonathan Kaplan, director of the Midwest health care consulting division in Chicago at Ernst & Young LLP: ''As you erode the revenue side, they're going to have to dramatically redesign their business to make sure they can survive.''

Already, U of C says it won't fill 115 positions this year, and UIC is eliminating 250 positions and has initiated a hiring freeze. Experts say more layoffs are likely.

''What's going to happen is, we'll see cutbacks in programs,'' says U of C's Mr. Muller. ''If you cut back programs, then patients stop coming and doctors stop using you. That's not in anyone's interest.''

Rush-Presbyterian, which includes expenses for Rush University and faculty practices in its financial results, posted an operating loss of $18.7 million on revenues of $520.4 million in the fiscal year ended last June 30, on top of an operating loss of $235,000 the previous year. Losses at the university and the faculty practices more than offset operating income of $8.3 million at the hospital—down from $28.7 million in 1997—according to President and CEO Leo M. Henikoff. He cites eroding Medicare revenues as the reason for the decline.

In fact, Rush kicked off an aggressive three-year cost-cutting program in 1997, aimed at saving $120 million, in anticipation of Medicare cuts in 1998.

''A number of people thought that was overkill,'' says Dr. Henikoff. ''It turns out it was underkill.''

Rush is also taking steps to boost growth, including plans to buy or build 24-hour ambulatory surgery centers in the suburbs, and to expand Rush System for Health, a network of six hospitals with Rush-Presbyterian as a tertiary hub. He also says the recent recruitment of Dr. Leonard Cerullo to head

Rush's neurosurgery department will attract more patients.

U OF C VULNERABLE

While Rush tries to increase patient volume, competitors are undertaking changes of their own.

University of Chicago, whose operating income dropped a whopping 72% to $6.3 million last year from 1997, also is particularly vulnerable to federal cutbacks.

If losses associated with its Medicaid managed care plan and a now-divested Meyer Medical Group and other affiliates are included, the medical center posted a consolidated operating loss of $32.6 million last year.

Even though the losses are steep, observers say U of C is taking steps in the right direction, including selling money-losing ventures.

Still, U of C has a high dependence on Medicaid, receiving 26% of revenues from the federal-state health insurance program for low-income patients, while Loyola receives 14%; Rush, 13%, and Northwestern, 11%, according to IHHA.

Northwestern Memorial Hospital, located in the affluent Streeterville neighborhood, is perhaps the best-positioned to withstand the Medicare cuts. Although it reported a 35% drop in operating income to $35 million last year, it has significant investments in marketable securities, as well as a desirable payer mix. However, the hospital must absorb depreciation costs and risks associated with its new, $580-million building, which it funded with debt and cash. Hospital officials say the new facility is more efficient and will save costs in the long run.

A RUSH-UIC MERGER?

Loyola University Medical Center, which posted operating income of $6.2 million in 1998, after a loss of $4.2 million in 1997, is trying to shore up operations at its 19 outpatient care clinics.

UIC earlier this year hired a consulting group to help improve operations. In the first nine months of fiscal 1999 ended March 31, the medical center reported a $5.8-million operating loss, following a loss of $7.1 million in fiscal 1998 due to a drop in revenues and patient volume.

In response, UIC could turn to mergers or affiliations, including a potential merger with its nearby competitor, Rush.

Although Dieter Haussmann, vice-chancellor for health services at UIC, says he's not in formal talks with Rush, he doesn't rule out the option. The most difficult task for any academic medical center would be the melding of medical schools, he adds.

''It's clear that, ultimately, there have to be fewer academic medical centers,'' says Mr. Haussmann, ''How we get there is the big question.''

Observers say UIC would have more to gain from a Rush-UIC combination than Rush because UIC could gain patients from Rush's network. Dr. Henikoff agrees with that assessment, and says a merger with another teaching hospital wouldn't make sense for Rush.

FINANCE-DRIVEN OUTCOME

''When you end up with two hospitals, you don't save money,'' says Dr. Heinkoff. ''You would get saddled with another infrastructure. The last thing I want is an infrastructure that isn't utilized.''

Still, if Congress doesn't reverse the cutbacks, mergers here may be inevitable.

Says consultant Mr. Anderson: ''Financial pressures are going to drive very serious evaluations by boards of hospitals about whether the enemy across the street now needs to be their friend.''

MEDICARE FLU—OPERATING INCOME (LOSSES) FOR CHICAGO'S FIVE ACADEMIC MEDICAL CENTERS

[In millions]

	1998	1997
University of Chicago Hospitals	$6.3	22.7
Northwestern Memorial Hospital	35.0	53.9
Rush-Presbyterian-St. Luke's Medical Center, including Rush University and faculty practices	(18.7)	(0.2)
Loyola University Medical Center	6.2	(4.2)
University of Illinois at Chicago Medical Center	(7.1)	2.7

Source: Hospitals' financial statements.

[From the New York Times, May 31, 1999]

TEACHING HOSPITALS IN TROUBLE

The nation's teaching hospitals are facing deep financial trouble, brought on by the growth of managed care and cost-cutting measures in government health programs. Congress can help by restoring some cuts made to Medicare funding in 1997 that squeezed these institutions severely. But their long-term financial health will depend on new ways of financing their special missions. They also should be required to live by reasonable cost controls.

All hospitals are facing the same pressures, chiefly cuts in government payments and managed care's demand for lower hospital fees and shorter hospital stays. Most have responded by reducing staff and merging with other institutions. Teaching hospitals have also taken these steps, but their problems are compounded by the extra obligations that teaching hospitals have long assumed—training new doctors, conducting medical research and providing charity care for the poor. These functions have traditionally been indirectly underwritten in part by the private sector.

Managed care has changed that by making it much harder to pass along charity care and education costs through higher fees. At the same time, these hospitals have been especially hard hit by government cuts because they derive much of their revenue from Medicaid and Medicare patients. These pressures are especially severe in New York City, which has the nation's largest concentration of teaching hospitals. City hospitals have cut their staffs by 10 percent since 1993. Still, Gov. George Pataki has proposed trimming roughly $150 million in state Medicaid payments to hospitals in the new fiscal year, and Clinton Administration is also proposing further Medicare cuts.

But the worst blow comes from the 1997 Balanced Budget Act. That law has produced the welcome and unexpected result of actually cutting Medicare expenditures in the first half of this fiscal year. But it also had a disproportionate impact on teaching hospitals. Among other cost controls, the law sharply cut the Federal subsidy for graduate medical education that is financed as part of Medicare. By 2002, when all the cuts are fully phased in, New York State hospitals will have lost $5 billion in Federal revenue, with $3 billion of that squeezed out of the metropolitan area hospitals.

Senator Daniel Patrick Moynihan introduced legislation that would reduce some of the damage. One bill would freeze the graduate medical education subsidy, rather than allow further annual reductions for the next two years, as required under the 1997 law. That would save teaching hospitals $3 billion in losses over five years. Another bill would take the Federal subsidies for serving low-income patients that are included in payments to Medicare managed-care plans and redirect the money to the hospitals that provide the care. In theory, Medicare H.M.O.'s pass on the subsidy to the hospitals, but in practice they often do not. A similar bill would redirect the subsidy for training nurses from Medicare H.M.O.'s to teaching hospitals.

Congress should make these adjustments without unraveling other cost-containment measures of the 1997 law. Mr. Moynihan has also proposed broader legislation that would spread the burden of paying for medical education. His plan would establish a separate Medical Education Trust Fund that would be financed by a fee levied on private health insurance premiums, as well as contributions from Medicaid and Medicare. The bill calls for an advisory commission to debate alternative approaches.

Something has to be done to shore up this key part of the nation's biomedical infrastructure. Simply plugging holes in the current patchwork of funding will not insure stability for the future.

[From the New York Times, May 6, 1999]

TEACHING HOSPITALS, BATTLING CUTBACKS IN MEDICARE MONEY

(By Carey Goldberg)

BOSTON, May 5.—Normally, the great teaching hospitals of this medical Mecca carry an air of white-coated, best-in-the-world arrogance, the kind of arrogance that comes of collecting Nobels, of snaring more Federal money for medical research than hospitals anywhere else, of attracting patients from the four corners of the earth.

But not lately. Lately, their chief executives carry an air of pleading and alarm. They tend to cross the edges of their palms in an X that symbolizes the crossing of rising costs and dropping payments, especially Medicare payments. And to say they simply cannot go on losing money this way and remain the academic cream of American medicine.

The teaching hospitals here and elsewhere have never been immune from the turbulent change sweeping American health care—from the expansion of managed care to spiraling drug prices to the fierce fights for survival and shotgun marriages between hospitals with empty beds and flabby management.

But they are contending that suddenly, in recent weeks, a Federal cutback in Medicare spending has begun putting such a financial squeeze on them that it threatens their ability to fulfill their special missions: to handle the sickest patients, to act as incubators for new cures, to treat poor people and to train budding doctors.

The budget hemorrhaging has hit at scattered teaching hospitals across the country, from San Francisco to Philadelphia. New York's clusters of teaching hospitals are among the biggest and hardest hit, the Greater New York Hospital Association says. It predicts that Medicare cuts will cost the state's hospitals $5 billion through 2002 and force the closing of money-losing departments and whole hospitals.

Often, analysts say, hospital cut-backs closings and mergers make good economic sense, and some dislocation and pain are only to be expected, for all the hospitals' tendency to moan about them. Some critics say the hospitals are partly to fault, that for all their glittery research and credentials, they have not always been efficiently managed.

''A lot of teaching hospitals have engaged in what might be called self-sanctification—'We're the greatest hospitals in the world and no one can do it better or for less'—and that may or may not be true,'' said Alan Sager, a health-care finance expert at the Boston University School of Public Health.

But the hospital chiefs argue that they have virtually no fat left to cut, and warn that their financial problems may mean that the smartest edge of American medicine will get dumbed down.

With that message, they have been lobbying in Congress in recent weeks to reconsider the cuts that they say have turned

their financial straits from tough to intolerable.

Hospital chiefs and doctors also argue that a teaching hospital and its affiliated university are a delicate ecosystem whose production of critical research is at risk.

''The grand institutions in Boston that are venerated are characterized by a wildflower approach to invention and the generation of new knowledge,'' said Dr. James Reinertsen, the chief executive of Caregroup, which owns Beth Israel Deaconess Medical Center. ''We don't run our institutions like agribusiness, a massively efficient operation where we direct research and harvest it. It's unplanned to a great extent, and that chaotic fermenting environment is part of what makes the academic health centers what they are.''

Federal financing for research is plentiful of late, hospital heads acknowledge. But they point out that the Government expects hospitals to subsidize 10 percent or 15 percent of that research, and that they must also provide important support for researchers still too junior to win grants.

A similar argument for slack in the system comes in connection with teaching. Teaching hospitals are pressing their faculties to take on more patients to bring in more money, said Dr. Daniel D. Federman, dean for medical education of Harvard Medical School. A doctor under pressure to spend time in a billable way, Dr. Federman said, has less time to spend teaching.

Whatever the causes, said Dr. Stuart Altman, professor of national health policy at Brandeis University and past chairman for 12 years of the committee that advised the Government on Medicare prices, ''the concern is very real.''

''What's happened to them is that all of the cards have fallen the wrong way at the same time,'' Dr. Altman said. ''I believe their screams of woe are legitimate.''

Among the cards that fell wrong, begin with managed care. Massachusetts has an unusually large quotient of patients in managed-care plans. Managed-care companies, themselves strapped, have gotten increasingly tough about how much they will pay.

But the back-breaking straw, hospital chiefs say, came with Medicare cuts, enacted under the 1997 balanced-budget law, that will cut more each year through 2002. The Association of American Medical Colleges estimates that by then the losses for teaching hospitals could reach $14.7 billion, and that major teaching hospitals will lose about $150 million each. Nearly 100 teaching hospitals are expected to be running in the red by then, the association said last month.

For years, teaching hospitals have been more dependent than any others on Medicare. Unlike some other payers, Medicare has compensated them for their special missions—training, sicker patients, indigent care—by paying them extra.

For reasons yet to be determined, Dr. Altman and others say the Medicare cuts seem to be taking an even greater toll on the teaching hospitals than had been expected. Much has changed since the 1996 numbers on which the cuts are based, hospital chiefs say; and the cuts particularly singled out teaching hospitals, whose profit margins used to look fat.

Frightening the hospitals still further, President Clinton's next budget proposes even more Medicare cuts.

Not everyone sympathizes, though. Complaints from hospitals that financial pinching hurts have become familiar refrains over recent years, gaining them a reputation for crying wolf. Critics say the Boston hospitals are whining for more money when the only real fix is broad health-care reform.

Some propose that the rational solution is to analyze which aspects of the teaching hospitals' work society is willing to pay for, and then abandon the Byzantine Medicare cross-subsidies and pay for them straight out, perhaps through a new tax.

Others question the numbers.

Whenever hospitals face cuts, Alan Sager of Boston University said, ''they claim it will be teaching and research and free care of the uninsured that are cut first.''

If the hospitals want more money, Mr. Sager argued, they should allow in independent auditors to check their books rather than asking Congress to rely on a ''scream test.''

For many doctors at the teaching hospitals, however, the screaming is preventive medicine, meant to save their institutions from becoming ordinary.

Medical care is an applied science, said Dr. Allan Ropper, chief of neurology at St. Elizabeth's Hospital, and strong teaching hospitals, with their cadres of doctors willing to spend often-unreimbursed time on teaching and research, are essential to helping move it forward.

''There's no getting away from a patient and their illness,'' Dr. Ropper said, ''but if all you do is fix the watch, nobody ever builds a better watch. It's a very subtle thing, but precisely because it's so subtle, it's very easy to disrupt.''

[From the Chicago Tribune, Apr. 25, 1999]

MEDICARE CUTS HIT BIG CENTERS

TEACHING COSTS LOWER IMMUNITY

(By Bruce Japsen)

For years Dieter Haussmann has been far from the tremors of managed care, but the government's effort to drastically slow Medicare spending growth is quickly pushing him toward the epicenter.

As vice chancellor for health services at the University of Illinois at Chicago Medical Center, Haussmann was forced to disclose recently a deficit of $8 million that will result in a hiring freeze and the elimination of more than 250 jobs at the West Side academic medical center.

Although UIC said the shortfall was ''unexpected,'' the changing economic landscape made it bound to happen sooner or later.

Like all academic medical centers, UIC is more vulnerable than community hospitals to managed care, which emphasizes low-cost outpatient care. Teaching hospital costs are traditionally higher because such hospitals also train the nation's future doctors and conduct cutting-edge research.

Until federal spending began slowing under the Balanced Budget Act of 1997, Chicago teaching hospitals seemed largely immune to financial forces squeezing hospitals elsewhere. Health maintenance organizations—the most restrictive form of managed-care insurance when it comes to paying medical-care providers fixed rates—insure only one in four Chicago-area consumers and the insurance industry is largely fragmented.

''Maybe we are late compared to other academic medical centers,'' Haussmann said.

Now, with HMOs gaining more leverage here through consolidation and with Medicare slicing millions from hospitals' projected revenues, everything from more job cuts to mergers may be in store for Chicago's five major academic medical centers, analysts say.

A substantial number of the more than 22,000 workers at UIC, Rush-Presbyterian-St. Luke's Medical Center, University of Chicago Hospitals, Northwestern Memorial Hospital and Loyola University Medical Center could be affected.

This trend has already passed through other markets, where storied teaching hospitals have merged and been forced to make deep cuts in their workforces.

For example, Massachusetts General Hospital in Boston said it will eliminate 130 positions in the wake of a $5 million loss in its first quarter.

The hospitals' plight has been made worse by the Balanced Budget Act of 1997, which seeks to drastically hold down spending.

''The crunch is coming,'' said Haussmann, who concedes that consultants recently hired by the university may recommend a merger. ''We need to develop a strategic partnership with somebody.''

Indeed, without the pressure from managed care to keep Chicago consumers out of hospitals, acute-care hospitals here have remained bloated with beds and staffing. Much like at the rest of Chicago hospitals, one in three beds at UIC lies empty on any given day.

In fact, Chicago has more acute-care capacity than practically every major metropolitan area in the country, according to a Dartmouth Medical School study published last week by the Chicago-based American Hospital Association.

The Chicago area had 4.4 acute-care beds and 21.9 acute-care employees per 1,000 residents in 1996, compared with a national average of 2.8 beds and 13.2 employees per 1,000, the Dartmouth study said.

Even New York, Boston and Philadelphia—cities where academic medicine is also a hallmark of health-care service—ranked lower than Chicago in the study.

''If we have a higher utilization than New York, then that is a problem,'' said Ralph Muller, president and chief executive of University of Chicago Hospitals. ''We need to bring that down to be in line with national averages.''

With five major stand-alone academic medical centers, analysts say, excess capacity here is costing consumers and employers more than elsewhere. That's because consumers here aren't encouraged to use wellness programs and other outpatient services designed to keep people out of the hospital.

''There seems to be a great under-use of preventative services in some of the lesser managed-care areas,'' said Carol Schadelbauer, a spokeswoman for the American Hospital Association.

''It's a tremendous waste,'' said Larry Boress, executive director of the Chicago Business Group on Health, a business coalition that includes 65 employers that represent $1.5 billion in health-care spending. ''I don't think there is any doubt this is costing us. You have beds sitting empty and yet it's coming out of the budget [of the hospitals] to maintain those.''

But teaching hospitals here are now beginning to make serious efforts to reduce the size of their workforces. Last week, Michael Reese Hospital and Medical Center said it would lay off 400 full-time employees, while Muller said the University of Chicago ''will not fill well over 115 positions this year . . . and the number may get higher.''

The UIC has pared 200 hospital positions through attrition or retirements since the beginning of the year, and is looking to eliminate 50 more by next month.

''It's a long, slow struggle,'' Haussmann said. ''We aren't getting paid as much as we used to. The managed-care market is becoming much tougher.''

Chicago's other academic medical centers, too, saw their operating income drop last year when it came to operations. University of Chicago's operating income dropped by $10 million last year to $6 million.

Even cash-rich Northwestern Memorial Hospital saw its net operating income fall 35 percent last year to $34.9 million from $53.9 million in 1997. ''Medicare reimbursements were part of the decrease,'' said Northwestern Memorial spokeswoman Paula Poda.

Northwestern and University of Chicago are each getting more than $60 million less

from Medicare through 2002 than earlier projected. The UIC is amid a five year hit of $33.5 million out of a projected $334.5 million.

Most of Chicago's academic medical centers have remained well in the black, however, because of multimillion-dollar gains on their investment income. University of Chicago Hospitals, for example, made $50 million on stocks, real estate and other investments last year.

The UIC medical center's balance sheet would be in even worse shape if the hospital didn't get state support. Through the University of Illinois, the state provides the hospital a $45 million subsidy per year and another $32 million directly from the state for hospital employees' fringe benefits.

''In some ways, among the academic medical centers, we may be the first to come to grips because we don't have a big endowment that we can sort of exist on for awhile,'' Haussmann said. ''We have to go back to the state treasury . . . and that's not a very likely prospect.''

With UIC already losing money, the hospital's only recourse may be to form a partnership or enter into a merger with another hospital or academic medical center.

Over the last two decades, UIC has talked merger at various time, but negotiations have never come to anything, including talks with its neighbor across Polk Street, Rush-Presbyterian-St. Luke's Medical Center.

''Just because we tried in the past doesn't mean we wouldn't try again.'' Haussmann said of Rush. ''Circumstances are different for both of us.''

As operating margins here sink, U. of C.'s Muller said, it's only a matter of time before academic medical centers here will be swimming in red ink like those in other parts of the country.

''This is going to start putting hospitals like us in difficulty,'' Muller said. ''When you do that, you start weakening the regional health system.

[From The New York Times, Apr. 15, 1999]

HOSPITALS IN CRISIS

A deep financial crisis is spreading like a virus through the nation's teaching hospitals. It is undermining their honorable and historic mission, which has been to train new generations of physicians, to conduct critically important medical research and to provide treatment for, among others, the poor.

A devastating combination of financial pressures ''has produced a situation in which our best hospitals are now essentially all losing money,'' said Dr. Joseph Martin, dean of the Harvard Medical School. He was referring to hospitals in the Boston area, but similar pressures are being felt at teaching hospitals across the country.

The teaching hospitals (or, more accurately, academic medical centers) have been hammered by the Medicare cuts that were part of the Balanced Budget Act of 1997. As teaching hospitals are the key providers of the nation's charitable care, they are affected disproportionately by cuts in government funding. At the same time, they are being squeezed by the drastic reductions in payments that have resulted from the changeover to managed care in recent years.

Meanwhile, the cost of delivering care continues to rise. The bottom line has been an explosion of red ink that threatens not just the mission but the very existence of some of the finest teaching institutions.

''The only payers who help balance the books have been those who pay through private insurance, and the payments for that are declining as well,'' said Dr. Martin.

In California, the medical center known as UCSF Stanford Health Care expects operating losses of $50 million this year. Layoff notices have already been sent to 250 employees, and officials said 2,000 of the center's 12,000 staff members would probably be let go over the next year and a half.

Without the layoffs, UCSF Stanford would see an operating loss of $135 million next year, according to the center's chief executive, Peter Van Etten.

Inevitably the center's mission will be diminished. Said Mr. Van Etten: ''I have to say the services we will provide can't be of the same quality that we would provide with 2,000 more people.''

You cannot overstate the importance of teaching hospitals to the health care system in the U.S. They offer the most advanced and sophisticated treatment in the nation. They are essential to the health of the poor, providing nearly 40 percent of the nation's charitable care. They are also the places, as Neil Rudenstine, the president of Harvard, noted, ''where physicians get educated,'' where they get their first, carefully guided exposure to the connection between scientific study and the real world of clinical treatment.

And they are medical research centers, the places where cures are found, treatments developed, miracles realized.

Toying with the future of such a system is as dangerous as Russian roulette.

When asked yesterday how much of a threat the financial problems pose to the mission of the teaching hospitals, Mr. Rudenstine replied: ''It's a total crisis, a complete crisis. I think anybody who would call it less than that would really just not know what's going on. I'm not quite sure what the cumulative deficit of our four or five closely related hospitals is, but it's certainly well over $100 million so far, and we haven't even finished the year yet.''

The outlook is not good. The cutbacks in Medicare funding, the single biggest source of revenues for teaching hospitals, will accelerate over the next few years. This is not a case of administrators crying wolf. The situation is dire. The University of Pennsylvania Health System lost $90 million last year and the Temple University system lost nearly $25 million.

When he mentioned the financial losses at Harvard's affiliated hospitals, Mr. Rudenstine said: ''Two or three more years like that and you're going to see either some people go out of business or become for-profit institutions, which means they will drop the research and teaching components because those things don't make any money. They'll become perfectly good hospitals up to a certain level, but not up to the level at which we now treat disease, and not up to the level where you can actually train the best physicians.''

Teaching hospitals and academic medical centers are the primary sources for complex care. Continued failure to support these institutions threatens their long-term viability.

''Illinois' teaching hospitals need adequate funding to remain viable for people like . . .'' Vanessa Blaida, Age 21, Children's Memorial Hospital, Asthma Study.

''I was known as the girl who didn't have asthma,'' Vanessa Blaida explains about growing up with asthma. ''I would pretend I didn't have it, because I didn't want it.'' Instead, she played volleyball every fall, and softball every spring. She also missed weeks of school and spent days in the hospital.

Throughout college, Vanessa's illness grew worse. Though she continued to participate in sports, she was getting sicker and sicker. ''It was frustrating. I would be rushed to the local emergency room and the nurses would tell me I was just hyperventilating. I wasn't hyperventilating, I was having an asthma attack.''

In August of 1998, Vanessa became part of a year-long asthma study. Children's Memorial Hospital is one of only seven hospitals nationwide participating in the study to decrease the level of asthmatic morbidity.

Under careful supervision, Vanessa is trying a new experimental inhaler designed to prevent future asthma attacks, long-term.

Doctors monitor Vanessa's health with a Peak Flow Meter. Every morning she blows into the device which determines the level of her condition, and alerts her if she's getting sick. ''It's great because it gives the patient control over the illness. You can tell when you are getting sick and you know what to do to help yourself,'' she said.

Since she began using the experimental inhaler, Vanessa's condition has dramatically improved. ''Usually fall and spring are my worst times. I didn't get sick at all in the fall. I got a little sick in the spring, but I haven't had to go to the hospital at all. That's unusual for me.''

Vanessa graduated from St. Xavier University in May, with a degree in psychology. She hopes to become a counselor for chronically ill children. ''The thing that's so great about Children's Memorial is no matter what's wrong with you, they don't ignore you. They don't make you feel like an outsider. They're working to give children a normal life.''

''Illinois' teaching hospitals need adequate funding to remain viable for people like . . .'' Heather Marker, Age 27, Northwestern Memorial Hospital, Robert H. Lurie Comprehensive Cancer Center.

For 14 years, Heather Markel has struggled against systemic lupus. Systemic lupus is a devastating, chronic disease in which the immune system attacks normal tissue. It can cause joint inflammation, severe pain and permanent damage to internal organs.

During the spring of 1997, Heather's life changed. As a patient at Northwestern Memorial Hospital, Heather had access to one of the most cutting-edge treatments for lupus.

Northwestern Memorial Hospital is participating in the first comprehensive research program to develop techniques—traditionally used to treat cancer—to treat autoimmune diseases such as lupus, rheumatoid arthritis and multiple sclerosis.

Heather's treatment for lupus included chemotherapy and transplanted blood stem cells. Within ten days of the procedure Heather's immune system began to rebuild itself. For the first time in 14 years, Heather was free of the disease she had struggled with since childhood. She is currently planning on returning to medical school and hopes to fulfill her lifelong dream of becoming a physician.

The procedure was discovered through research at the Robert H. Lurie Comprehensive Cancer Center of Northwestern University. Northwestern Memorial Hospital's connection to Northwestern University, and its status as a teaching hospital, provides patients with cutting-edge technology and experimental treatments based on University research. To date Northwestern Memorial Hospital's program is one of the few in the country using this procedure.

Heather was the first person to receive the treatment, and doctors are optimistic about her condition.

''Illinois' teaching hospitals need adequate funding to remain viable for people like . . .'' Philip Gattone, Age 12, Rush-Presbyterian St. Luke's Medical Center, Rush Epilepsy Center.

Phil and Jill Gattone's son Philip began having seizures as a baby. Doctors diagnosed

Philip with intractable epilepsy. The disease interfered with Philip's development so much that by age six he still couldn't speak in full sentences.

An estimated 2.3 million Americans suffer from epilepsy. While about 75 percent find medications or other treatments to control their seizures, the other 25 percent, like Philip, try everything available to alleviate their seizures, but find no relief.

The Gattone's search for help from specialists around the country ended at the Rush Epilepsy Center. Rush-Presbyterian is one of the few hospitals in the nation that offers advanced treatment options and research capabilities for people with epilepsy.

Philip went through various tests at Rush to diagnose his condition and to discover the right way to treat his particular form of the disease. During the test period, Philip was videotaped 24-hours-a-day so doctors could identify his type of epilepsy, recording certain symptoms including facial expressions and unusual or abnormal behavior.

Doctors experimented with a variety of medications, but Philip's seizures persisted. His IQ was dropping, and he was losing critical cognitive abilities. His father, Philip Sr. said, ''We knew we had to do something.''

Doctors agreed that surgery was the only option. ''If you can stop epileptic activity at its original site, you can stop the spread,'' said Thomas Hoeppner, PhD., a Rush neuroscientist.

In 1993, Philip underwent the first of two surgeries designed to prevent epileptic activity in areas of the brain critical to speech, movement and sensation.

Philip, now 12, has been seizure-free for the last five years. His parents are thrilled to see their dark haired, bright-eyed son doing so well. ''This is what happens when research, dedication and commitment come together,'' said his father.

TERTIARY CARE IN ILLINOIS: A RESOURCE AT RISK

REQUEST

Because the costs associated with delivering more complex care limit the ability of these hospitals to compete on price in the health care marketplace, their continued ability to provide leading-edge technology and specialized care depends heavily on government reimbursement policies. Several bills that would give teaching hospitals and academic medical centers some relief from BBA cuts have been introduced in Congress. All deserve the support of our state's U.S. senators and representatives.

S. 1023/H.R. 1785, the Graduate Medical Education Payment Restoration Act of 1999, would freeze the IME payment reduction at its current level of 6.5%. It would restore nearly $90 million of Medicare funding to Illinois teaching hospitals and academic medical centers.

S. 1024/H.R. 1103, the Managed Care Fair Payment Act of 1999, would pay disproportionate-share hospitals (DSH) directly from Medicare for services provided to beneficiaries who are members of Medicare+Choice health plans.

S. 1025, the Nursing and Allied Health Payment Improvement Act of 1999, and H.R. 1483, the Medicare Nursing and Paramedical Education Act of 1999, would carve out funding for nurse and allied health training from payments to Medicare+Choice plans and pay the money directly to the hospitals that provide the training. Illinois Rep. Philip Crane (R-8th Dist.) is the sponsor of H.R. 1483.

Tertiary teaching hospitals and academic medical centers also support:

A halt in implementation of further DSH payment reductions.

Payment of 100% of their DME and IME costs in lieu of the current partial carve out under Medicare+Choice, beginning in FY 2000.

JULY 23, 1999.

DRAFT

As members of the Illinois Congressional Delegation, I am writing to share our concerns over the fate of Illinois teaching hospitals and academic medical centers absent some form of relief from reimbursement cuts authorized in the '97 Balanced Budget Act (BBA). While we recognize that all sectors of society must sacrifice to achieve BBA objectives, we strongly believe that the unintended consequences of BBA threaten the viability of these valuable health care resources. As envisioned, BBA was intended to cut $104 Billion from Medicare reimbursement to hospitals. However, BBA, if implemented as enacted, will result in nearly $200 Billion in reductions.

The people of the State of Illinois deserve and have come to expect the high-quality medical care delivered by our teaching hospitals and academic medical centers. The benefit derived by residents of every region of the state is incalculable. These teaching hospitals and academic medical centers are the primary providers of complex medical care and high-risk specialty services such as trauma care, burn care, organ transplants and prenatal care to all patients—regardless of ability to pay.

In fact, the 65 tertiary care teaching hospitals in Illinois provide approximately 63% of all hospital charity care in the state. Aggressive BBA cuts are jeopardizing their ability to fulfill their vital mission of maintaining state-of-the-art medical care and technology, providing quality learning and research environments, and serving as a safety net for those unable to pay.

Not only do these institutions enhance our health and physical well-being, they also are some of our largest employers and consumers and, as a result, are an integral part of our overall economy. In total, our Illinois teaching hospitals and academic medical centers employ more than 56,000 of our constituents and add almost $3 Billion to the state's economy in salaries and benefits alone.

Yet, despite the great benefits Illinois residents derive from our teaching hospitals and academic medical centers, these institutions suffer disproportionately under the BBA. In total, Illinois teaching hospitals face five-year reductions of more than $2.5 billion. Consequently, while teaching facilities comprise 27% of Illinois hospitals, they will bear the brunt of 59% of BBA reductions. These cuts are compounded by increasing fiscal pressures from managed care companies and inadequate Medicaid reimbursements on the state level.

We believe we must act now to prevent the unintended consequences of BBA from eroding the high quality medical care we in Illinois take for granted. We respectfully urge you to make relief for our teaching hospitals and academic medical centers a high priority in this legislative session.

Mr. Speaker, I am looking at an editorial from the Peoria Star Journal that says, ''Medicare Reductions Threatening Hospitals.''

I am looking at one from the St. Louis Post Dispatch that says, ''When Hospitals Get Sick,'' that hospitals can be sick if they are not being provided the necessary resources with which to operate.

I am looking at one from the Chicago Tribune which says, ''University of Illinois to cut hospital jobs, seek merger.''

I am looking at one from Crain's Chicago Business Magazine that says, ''Deep Medicare cuts draw blood at teaching hospitals,'' and they are not talking about the kind of blood that needs to analyzed. They are talking about the blood that is going to cause the institutions to hemorrhage; and, of course, if one does not stop a hemorrhage we know that institutions, as well as individuals, can die. If institutions die, then they threaten the life of communities.

I am looking at one from the New York Times that says, ''Teaching Hospitals in Trouble.''

Then one that says, ''Teaching Hospitals Battling Cutbacks in Medicare Money.'' Another editorial from the Chicago Tribune, ''Medicare Cuts Hit Big Centers.''

So all around America, both rural and urban, we are experiencing difficulties that unless there is relief we do not really know what to do about it. It is understandable if our economy was in bad shape, if we were on the verge of disaster, if we were on the verge of bankruptcy; but all of us continue to talk about how fortunate we have been that the economy has been holding steady, that we continue to experience economic growth. If we are experiencing economic growth, then it would seem foolhardy to allow institutions that provide the most needed of services to dissipate and perhaps even go under.

Now, there are some things that are being proposed. There are bills that have already been introduced that could provide some relief. One is Senate bill 1023 and House Resolution 1785. The Graduate Medical Education Payment Restoration Act of 1999 would freeze the IME payment reduction at its current level of 6.5 percent, and it would restore nearly $90 million of Medicare funding to Illinois teaching hospitals and academic medical centers. Obviously, we are asking people to support that legislation.

Senate bill 1024 and House Resolution 1103, the Managed Care Fair Payment Act of 1999, would pay a disproportionate share to hospitals directly from Medicare for services. So we would hope that these legislative initiatives would be seriously looked at by the Members of Congress and that we could move to provide the kind of relief that is necessary to keep our institutions alive, viable, healthy, and well.

☐ 1530

HURRICANE FLOYD DISASTER IN NORTH CAROLINA

The SPEAKER pro tempore (Mr. COOKSEY). Under a previous order of the House, the gentlewoman from North Carolina (Mrs. CLAYTON) is recognized for 5 minutes.

Mrs. CLAYTON. Mr. Speaker, I come from North Carolina, and there is, indeed, trouble in the land where I come from. There is great devastation. In fact, we have suffered the greatest devastation that we have ever suffered in