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Health Care Issues in Today's Economy

INTRODUCTION

How often have you heard speakers bemoan the crisis in health care that exists in the United States today? How many programs have you attended built around the theme of survival: the survival of private medicine, the survival of hospitals, the survival of home health services, to cite but three illustrations.

The slogans and catchy headlines are signs of a rather pervasive climate of apprehension among health policy experts. This concern is a concern about the future and the changes that will be necessary in health care delivery.

This year the Federal Government will spend approximately $55 billion dollars on the medicare program. Of this amount, approximately $34 billion will be spent on hospital services. We expect to spend $19 billion for services to the poor under the medicaid program. The States will spend another $16 billion. In summary, the Federal Government will spend approximately $75 billion this year for these two programs. Naturally, because of the extraordinary size of the two programs, increasing attention has been given to ways to moderate their growth. In these discussions, the most frequently mentioned area of potential reform is reimbursement policy. It is not the only area of potential reform, but it is the largest.

LESSONS OF THE PAST

The end stage renal disease program taught us that mistakes in reimbursement can be very costly, and can result in inefficiency and waste. It also taught us that medicare policy can change the face of health care delivery in ways that are not very positive. In the case of kidney dialysis it resulted in a massive shift of services away from an individual's home to an institutional setting. Care must be taken so the same mistakes are not repeated in other areas.

CURRENT ISSUES

Today any broad discussion about health care quickly evolves into a narrower discussion about health care costs. This is true of not only medicare and medicaid, but of any payment source. Needless to say, how we pay for services plays an important part in these discussions.

Health Care Costs

Health care expenditures amounted to $1,225 per person in 1981. 42.7 percent of these dollars came from public funds. Governments have recognized the medical cost problem since the early 1970's, but recognition of the problem has not brought about agreement on the solution.

Expenditures on all types of medical care have risen from $39 billion in 1965 to approximately $287 billion in 1981--from 6 to 9.8 percent of the GNP. The rise in costs of medical care is a worldwide phenomenon among industrial countries, irrespective of the method of financing care. In all of these countries, however, individuals rarely pay an amount equal to the value of the actual resources used for the health care they receive. Patients are often treated with new, expensive medical technologies which cost more to produce and operate, yet cost no more to them as individuals.

No one has yet decided how much is enough for health care; nor is anyone likely to. However, what we are likely to face in the near future is a depletion of the medicare trust funds, thereby forcing us to make decisions on spending priorities.

In 1982, through the Tax Equity and Fiscal Responsibility Act, we asked that cost savings be borne by all parties to the medicare program--hospitals, doctors, and beneficiaries. However, because we felt that cost savings imposed on physicians could all too easily translate into a burden on beneficiaries, most physicians were not affected by the changes we made. So in that sense, physicians represent an opportunity for additional cost savings for 1984. Indeed, we are committed to examining physician reimbursement in detail--seeking out changes that result in savings without reducing access to care or unreasonable increasing out-of-pocket expenses for beneficiaries.

Hospital Reimbursement

Hospitals, of course, are bearing the largest burden of the cuts made in the last two years. This should not be viewed as unusual given that over two-thirds of all medicare dollars are spent on hospital services ($37 billion in 1983). I would expect continued work on hospital reimbursement in the hopes of providing long term reform and moving us away from cost-based reimbursement. However, it is not likely that this will result in further substantial reductions in hospital payments over the next year or two.

The concept of prospective payment holds out the promise of a system that encourages institutional efficiency. I would hope that such a system could be made sensitive to the differing case loads in institutions so as not to do unreasonable harm to those who care for mentally ill, as opposed to physically ill, individuals.

The concept of case-by-case reimbursement through diagnosis related groups (DRGs) deserves our close attention. The Secretary's proposal explains away several problems as minor and without great impact. I'd like further discussion and greater assurances that the care provided patients who don't fit the mold of any one DRG for any reason--including very long or very short lengths of stay--will be adequately reimbursed.

Physician Reimbursement

Physicians are among the highest paid professionals in this country; the average income of physicians is about two and one half times that of the average family's income.

Recognizing that fact, physicians and other providers should be required to bear part of the burden of limits on program growth; we can't expect beneficiaries to bear increases in their out-of-pocket expenses if doctors aren't asked to moderate their fees at the same time.

Physicians have made a tremendous contribution to the medicare program. In examining their reimbursement, it is not our intention to punish, but rather to seek out incentives to encourage assignment and to encourage the efficient use of serves.

As the most influential group in the health care industry, and as those who are among the most highly paid professionals in the Nation, physicians should assist us in the very important task of reforming the reimbursement system and reducing the rate of growth in the medicare program.

Beneficiary Changes

Certainly beneficiary cost sharing and a restructuring of the medicare benefit package will also receive considerable attention. The Administration has made it clear that they intend to make a number of suggestions in these areas--and they will be given every consideration. We must keep in mind that whether or not Congress chooses to deal with steadily rising health care spending, it nevertheless faces a major crisis regarding the financial condition of the medicare program that will have to be addressed in the near future.

The important thing to keep in mind during these discussions is the terrible problems faced by medicare if no changes take place. If you think we face serious deficit problems with the social security cash program, you're in for a big surprise when you look down the road at medicare's future. Using the current optimistic assumptions, medicare could literally go broke sometime toward the end of the decade, perhaps as early as 1987 or 1988.

Non-Institutional Care

There will continue to be great interest in seeking alternatives to institutional care. This past year we agreed to cover hospice services; in recent years we expanded the home health benefit. Both of these could be considered "liberalizations" of the program. Further changes of this nature will depend in large part on our ability to finance the current benefits and to reduce the extraordinary rate of increase in the hospital side of the program. Our discussions in medicaid, and its large long term care component, will also have a bearing on our consideration of medicare changes.

As far as the low income cash assistance programs are concerned, to a large extent I don't believe further reductions will be possible or appropriate. The AFDC program, and even the nutrition programs for the poor, like WIC, have seen substantial cuts in the last two years. Further cuts could seriously hamper these programs from providing the support needed so desperately by the poor in our society. In fact, some increases in spending may be necessary.

Medicaid

- In medicaid there do not appear to be many major opportunities for cost savings, but we can do something. We certainly intend to continue providing the States with the flexibility necessary to allow them to improve program operations and service delivery. We may actually learn something from the medicaid programs in their use of community based resources.

Maternal and Child Health

- We must revisit the block grants--particularly those dealing with poor women and children--and determine whether or not they are sufficient to provide the services required. Investments of money into health services and food for women and children have proven to be a very wise use of money for both the States and the Federal Government.

Health Insurance for the Unemployed

- Increasing attention is being given to the problems faced by many unemployed individuals in this country, who, along with losing their jobs, also lose their health insurance coverage. The principal source of insurance coverage for most workers is the group health plans offered by employers. For that reason, workers generally lose health insurance when they lose their jobs.

- Under most health insurance plans, benefits end within a month after a person is laid off. Many insurance companies give laid off workers an opportunity to continue coverage by switching to a non-group policy covering an individual or family. However, the premiums are higher and the benefits are sometimes more limited.

- While recognizing the difficulty of proposing any new plan that might incur additional costs to the Federal or State Government--it might be worth our while to begin to examine ways of assisting the unemployed in the purchase of health coverage.

- For example, we might use revenues from a source like a cap on the deductibility of health insurance premiums to finance the purchase of health benefits from a State medicaid plan. The unemployed worker might be expected to bear some of the cost of the premium with the State and Federal Government picking up the rest.

- It seems to me that if we agree to try to resolve the problem of health benefits for the unemployed we should first look to existing systems to provide and administer that coverage, rather than creating a new system.

- I raise this suggestion for discussion purposes. It may not be feasible given our serious economic crisis, but it is certainly worth our consideration.

Tax Cap on Health Insurance Premiums

- We should again anticipate discussions on a proposal to place a limit on the amount an employer may contribute for an employee's health benefits that is not considered taxable income to the employee.

- There are still a number of questions to be resolved with respect to a so-called tax cap. These include the level at which the cap is set; should there be a national cap or one which varies in different areas of the country, thereby recognizing differing costs of care; how often the limit is updated; and how do we prevent adverse selection--the case where all the healthy choose low option insurance and all the ill high option.

- The proponents of such a proposal believe such a cap would encourage employees and employers to seek out less costly insurance. Many of you, I am sure, are concerned that in seeking out less costly insurance, the employee/employer may drop mental health benefits. Of course, there is always this possibility. In fact, it could happen to any benefit. So it will be increasingly important for you to document the cost savings that result from the kind of services you provide.

- Many believe our generous tax treatment of health benefits has led to excessive coverage. It remains to be seen whether a tax cap would change consumer behavior in the right way. For example, are the low income more likely to choose the least amount of coverage--and place themselves at financial risk they can ill afford?

- It is not likely that we on the Federal level would attempt to establish a minimum benefits package in conjunction with a tax cap. I believe that is clearly the jurisdiction of the State insurance commissioners and in the hands of labor and business. This will make it even more important for you to devise ways of proving the value of your services, when people are looking to reduce benefits.

CONCLUSION

I've neither lost faith with the American health care system nor become unreasonably skeptical. It is, however, fair to say that I have become more cautious. We have the finest health care system in the world--but that doesn't mean more is always better, or that there is no room for improvement or change.