United States Senate
COMMITTEE ON FINANCE
WASHINGTON, D.C. 20510

April 6, 1984

TO: SENATOR DOLE

FROM: FINANCE COMMITTEE HEALTH STAFF

RE: SPEECH TO THE KANSAS DIABETIC ASSOCIATION

You are scheduled to speak at the annual meeting of the Kansas Diabetic Association on Saturday, April 7, in Wichita. You will be speaking from 3:15 to 3:45 before a group of about 175, composed of approximately 40 physicians, 100 nurses and allied health professionals, and 35 diabetics and persons concerned with the issues surrounding the care of diabetics.

The Association is interested in hearing you address health care policy trends at the Federal level generally and also with respect to diabetes care and research. They are especially interested in the future of outpatient and community-based care for diabetics relative to medicare and medicaid.

Talking points for your speech are attached.

TALKING POINTS

SENATOR BOB DOLE

ANNUAL MEETING OF THE

KANSAS DIABETIC ASSOCIATION

April 7, 1984

Wichita, Kansas

- The revolution in the health care industry that we have seen since the passage of Medicare and Medicaid will no doubt pale in comparison to what the next five to ten years will bring.

- Recent estimates show the Medicare hospital trust fund as being depleted as early as 1989. This financing problem is more than anything else, the result of rapidly growing hospital costs. Such costs are expected to increase at an average annual rate of 11.1 percent from now until 1995, while the basis for trust fund income is expected to grow at an annual rate of only 7.3 percent.

- Hospital costs are not the only element of the medicare program that have and are expected to experience rapid growth. Physician fees under Part B of the program have increased at an annual rate of over 11 percent in recent years.

- Both in terms of total outlays and total benefits per enrollee receiving reimbursement, the rate of growth for Part B of Medicare continues to exceed that for Part A. Part A benefits per enrollee receiving care are 58 percent higher than the projected fiscal year 1985 medical care component of the CPI, but Part B benefits are 100 percent higher.

- The high cost of health care in this nation, not just the cost of Medicare, is a real problem. A problem for which everybody has someone to blame. We have heard that it's the hospitals, the growing number of elderly, improved technology, the physicians, third party coverage, government regulations, etc. Clearly it's a problem in which all these things share some blame.

- 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.

- Health care expenditures amounted to $1,225 per person in 1981. 42.7 percent of these dollars came from public funds.

- The Administration estimates that current law benefit and administrative outlays under Medicare will be $76.8 billion in fiscal year 1985. Of this amount, benefit payments will account for $74.8 billion. This represents an increase of 15.9 over fiscal year 1984 benefit payments of $64.6 billion.

- The health care market itself is atypical of the perfect market for goods and services envisioned by standard economic theory. More than any other market, it is dominated by third-party payers, that is, by persons or organizations who purchase care on behalf of those who consume it. In 1981, two-thirds of personal health care expenditures were made by the government or by private health insurance. To that extent, consumers of health care are isolated from the true price of health care, and tend to consume more care than they would were they to pay directly the full price of the goods and services they receive.

- We need the cooperation of business and labor in solving these problems. We cannot be expected to ask medicare beneficiaries to pay more out of their pockets, and have their benefits changed, if those who are covered by private insurance are not asked to do the same.

- In the next weeks and months ahead we are going to begin to grapple again with the pressures that face the system. Those related to the solvency of the Medicare trust fund and those relating to the costs and utilization of the system. The coordinated efforts of all participants in the health care system will be vital to this struggle.

The Budget Deficit

- The Senate Finance Committee has made significant progress in addressing the deficit. After reviewing various recommendations for spending reductions and tax increases, the Committee recently completed a "deficit reduction package."

- Last year the budget process stumbled over the issue of spending versus revenue, because the budget resolution called for a large tax increase--$73 billion over three years--but only very modest restraints on spending. There is a lesson to be learned here. Balance is essential, compromise is necessary, and no one segment of the budget is adequate to the task where the deficit is concerned.

- As you know, the FY 1985 spending cuts proposed for Medicare and Medicaid contain nothing new. In fact, last

year's proposal to restructure beneficiary cost-sharing and provide catastrophic hospital insurance coverage was not included in this year's proposals. This does not mean that a restructuring of Medicare benefits will not be considered. The change to prospective rather than cost-based payments for hospitals has changed the degree to which we must rely on coinsurance and the spell of illness limitation to control inappropriate utilization. We must revisit these issues as the payment system has changed incentives for both hospitals and patients.

Medicare Solvency

- It would be unfair to you to suggest that our concerns with the continued escalation in the cost of care disappeared with the enactment of prospective payment.

- The cumulative projected deficit in the HI trust fund is so large -- $300 to $400 billion by 1995 -- that to maintain solvency will require substantial policy changes. To bring the hospital insurance program into close actuarial balance, either outlays will have to be reduced by 32 percent or income increased by 48 percent.

- Increased beneficiary cost sharing, hospital cost reductions, and higher payroll tax rates are but three options likely to be considered by the Congress to close the gap between revenues and outlays.

- Cutting benefits or raising taxes -- a dilemma that paralyzed social security reform for years. Medicare will be no easier to deal with, but deal with we must. As medical technology advances and longevity increases, the amount of money that the Nation could spend on health care is almost boundless.

- Some would argue that the problem with increasing costs is not the fault of the elderly or disabled, but rather the physician who orders the services, or the fact that we are biased in favor of institutional care over home care. Clearly the responsibility for the program's problems must be shared, as should the solution.

- There are those who have already begun to press for the establishment of a new Presidential commission to address these issues. I would argue that first we ought to allow the Congress an opportunity to do what it is here to do. in my view, we should revive the bipartisan spirit that marked the success of the social security rescue plan.

- In considering changes in medicare, our desire is not to simply cut another program. It is rather to protect one of

the most important programs we as a Nation offer our citizens.

- In solving the medicare crisis and the crisis on healthcare costs I believe that we need to consider all possible options. These include Democratic proposals, the recommendations of the Advisory Council on Social Security, and recommendations from other sources. We should not limit our options, nor should we allow ourselves to think of the various options as mutually exclusive. The solution we may adopt will very likely reflect variations of several different options, each thought by someone, at some time, to be a solution in its own right.

- On April 9, 1984, the Finance Committee will hold a hearing during which the Social Security Advisory Council will present to the Committee its recommendations regarding medicare. This hearing will provide us the opportunity to begin to examine all the options in earnest.

Physician Reimbursment

- In 1983 we directed staff to begin the data collection necessary to enable us to examine our current reimbursement methodologies. In October a document was published containing such information.

- In the fall of the year both the House and Senate considered some limited changes in the context of the budget legislation --these changes were not designed to resolve the underlying problems. They were designed very honestly, to help reduce our expenditures, while we sorted out the bigger questions.

- The next step, I believe, is to sit down with the principals and define the problems including what to do about assignment, and outline the alternatives.

- To this end, I will be asking representatives from medical speciality groups, consumer groups, the Institute of Medicine, the business community, and the insurance industry and others to sit down with us in a series of informal meetings to hammer out these issues. It is only in this fashion that I believe we can resolve the very difficult issues before us.

Long-Term Care Services

- Changing demographics have made long-term care spending the fastest growing segment of the U.S. health care industry. Average annual increases in our national expenditures for nursing home care, for example, consistently exceed the

average for all other health expenditures, including hospital care.

- Between now and the turn of the century, the most vulnerable population for long-term care, those over 85 years of age, will grow by 204 percent, at a rate more than two and half times that of the total population.

- In the health care field, as you well know, the implications of this growth in this population are enormous for the system as a whole and for Medicare in particular.

- The financing of long-term care services is shared almost equally by Medicaid and out-of-pocket exenditures by the family or elderly individual. Neither private insurance nor medicare play a large role in the financing of long-term care.

- Most publicly-financed long-term care services now are being provided in costly institutions although elderly persons would prefer to receive care at home from community providers.

Diabetes

- Approximately $10 billion is spent annually to treat the 6 million diagnosed diabetics in this country. It is estimated that there are 5 million more Americans who are not aware that they have diabetes.

- In addition to being the fifth leading cause of death by disease, diabetes takes its toll through the devastating and costly complications it can cause. Diabetics are more than twice as prone as nondiabetics to coronary heart disease and stroke, and represent nearly 20 percent of all end-stage renal disease patients entering hemodialysis programs. Diabetics are also hospitalized 2.5 times more frequently and have longer average hospital stays than nondiabetics.

- If we are to achieve our goals of controlling costs and providing quality care, our focus should be on research, prevention and the efficient delivery of care. Educational programs that increase public awareness of the warning signs of diabetes, who is most susceptible to becoming diabetic and the seriousness of the disease are important. Your continued efforts in this area are crucial to the control and prevention of diabetes.

- It is also important to remove those factors in our health care system which impede the treatment of diabetes, and

thus incur unnecessary expense to our Federal health programs.

- Federal funding for diabetes research totaled $72.2 million in 1981. That funding went to one of the 11 institutes composing the National Institutes of Health (NIH) which is responsible for investigating how diabetes can be prevented, better controlled or cured.

- In the area of health care generally there is great interest in increasing the availability and utilization of community-based services. This will be especially important to the diabetic population as new methods of treatment which involve outpatient services and monitoring blood glucous levels in the home become more common.

- In the area of long-term care, for example, Congress has begun to focus its attention on program changes that would encourage the development of community alternatives to institutions. Two years ago, Congress acted to allow states significantly greater flexibility in reimbursing home and community-based care, and currently the Finance Health Subcommittee is holding a series of hearings on initiatives that would redirect public funding from institutions to community-based programs.

CONCLUSION

Tough times are still ahead, and it is important that we all work together in seeking out answers to the questions before us.

I believe we have the same goals in mind: a strong, healthy economy and a strong, healthy people. Your committment to quality care can help to make these goals a reality.