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

November 23, 1984

M E M O R A N D U M

TO: SENATOR DOLE

FROM: SHEILA BURKE

SUBJECT: SPEECH FOR RADIOLOGICAL SOCIETY OF NORTH AMERICAN (RSNA)

You are scheduled to address the RSNA on Monday, November 26, 1984, at 9:00 a.m., breakfast begins at 8:30 a.m. The meeting is being held at the Washington Hilton, in the Georgetown West Room.

The group will be made up of 100-150 of the top executives from the manufacturing firms involved in the development of equipment used by radiologists. They have asked that you speak for 20-30 minutes on the deficit and on possible changes in medicare. Attached for your use are talking points on these subjects.

I will plan to meet you at the Hilton unless I hear from you otherwise.

Attachments

REMARKS OF SENATOR DOLE

RADIOLOGICAL SOCIETY OF NORTH AMERICA

Monday, November 26, 1984--Washington Hilton, Washington D.C.

1. Our Economic Progress

o Our spectacular recovery remains on track and appears to be moderating to a pace that can be sustained in the years ahead. Real GNP grew 6.1% in 1983, and continued at a 10.1% rate in the first quarter of 1984, and 7.5% in the second quarter. Even with the slower growth in the 3rd quarter, this is one of our strongest recoveries.

o With national unemployment down to 7.4%, this recovery has created 6.4 million jobs. Factories are operating at the highest capacity levels in 4 years, close to 82%. And the investment needed to sustain future growth is being made: businesses plan to increase spending on plant and equipment by 14.8% this year, the biggest increase in 18 years.

o The best news about this recovery is that inflation is staying low. Producer prices in 1983 showed that smallest increase since 1984. The 1983 CPI increase was just 3.8%, and consumer prices indicate we can sustain strong growth with low inflation. Consumer price increases increased by 4.1% in fiscal 1984, and producer prices have declined in each of the last two months.

o Growth, lower inflation, and major tax relief have translated into real income gains for all Americans. Real personal income has risen by $116 billion since the low point of the recession (August 1982). For the first time since 1978, real income is growing.

o All the trends in the economy look good. Most observers believe the recent drop in the economic indicators just show a moderating pace of recovery. Meanwhile the prime rate--which rose from 6.5% to 21.5% under Carter-Mondale--stands at 12%. The misery index, which peaked at 24.5% in March of 1980, is around 11%. Auto sales and housing starts are up.

2. The Budget And The Deficit

Nature Of The Deficit Problem

o After several years of running budget deficits that approach the $200 billion mark, some people seem to be getting complacent about the problem. Since the economy has continued to do well, with low inflation and strong growth, why worry about the deficit?

o The answer is that everything we have achieved for the economy in the last several years is put at risk unless we deal with the deficit. And part of the problem is that the public can't get very excited about the deficit dilemma. It seems we need to have a crisis on our hands, or some kind of visible faltering in the economy, to convince people of the urgency of reducing the budget deficit.

The Real Point

o We have heard a lot of campaign rhetoric about who or what caused the deficit. That is beside the point: everyone is to blame, because all of us together have put more demands on the government than we are willing to finance through taxes. Unless we lower some of our expectations for government involvement--meaning reduced Federal spending--deficits will persist.

o Sustained deficits in the $200 billion range are a real threat to continued recovery. Unless deficits decline we will either have to absorb Federal borrowing with higher inflation, or accept slow growth and rising unemployment as the Federal government absorbs the bulk of available credit. Without assurance that inflation will remain under control and credit available at acceptable rates of interest, business will not expand through new investment, and jobs will not be available for our sons and daughters when they are ready to enter the workforce.

Risks Ahead

o Time is of the essence, because we are at the point where economic expansion will either continue, competing against heavy Treasury borrowing, or the recovery will slow and possibly slip into recession. In either event the deficit problem will compound itself: each year that we add $200 billion in new Federal debt adds about $15 billion to the next year's interest costs. The exploding cost of servicing the Federal debt will make controlling spending that much more difficult each year.

3. The Crises In Health Care

o The rising costs of traditional illness care are forcing us to reexamine not only our priorities as a Nation, but also as individuals. In reviewing these priorities we must look at how our limited dollars can best be spent and how the financial responsibilities for the provision of health services can best be shared.

o While on one hand we are the "lean cuisine" generation; we continue to smoke and fail to exercise. And perhaps even more importantly we are looking down the road to future generations that will live longer, be more expensive to care for, and perhaps have fewer family members to turn to for assistance.

o Between 1960 and 1983, total national health expenditures more than doubled as a percent of the gross national product (GNP) from 5.3 to 10.8 percent. The Federal share of national health expenditures jumped from 11 percent to 29 percent during this period, a three-fold increase caused primarily by the enactment of medicare and medicaid in 1965 and their subsequent rapid growth.

o From the perspective of the Federal Government, the Medicare program, the VA health system, CHAMPUS and programs like the Indian Health Service, are of particular concern. In the case of each of these programs the Federal Government serves as a major purchaser of services, and as a result has had an enormous impact on health care costs and on the organization of health care services.

o In recent years Medicare has been the particular subject of a great deal of debate. We are currently told that the medicare hospital insurance trust fund will be exhausted by the mid 1990's, and that to maintain solvency will require major policy changes because the projected deficit is so high. To bring the hospital insurance program into close actuarial balance, the actuaries have explained that either outlays will have to be reduced by 32 percent or income increased by 48 percent.

o All aspects of medicare can be expected to be considered and we seek out ways to shore up the program. It is fair to say, however, that there is currently no apparent consensus on one particular plan of action.

o The one thing that people do seem to agree on is the success of the medicare program in meeting its early goals. In early 1963 half of the aged had no private health insurance and only 68 percent saw a physician at least once a

year; now 83 percent do. Fully 93 percent of the elderly have a regular source of health care. Most, including the elderly poor, utilize private physicians or clinics, and relatively few continue to use hospital outpatient departments or emergency rooms for their primary source of care.

o When we seek out solutions to medicare's problems we must be sure to maintain these advances while still doing a much better job of moderating its cost growth.

4. The Role of Health Care Technology

o The extraordinary growth in the introduction and use of technology has been blamed for much of escalation in health care costs generally and medicare specifically.

o Medicare's beneficiaries, elderly and disabled Americans, are on average sicker than the general population and are disproportionately high users of health care services in general and medical technology in particular. Every class of medical technology--with the exception of obstetrical, pediatric, and possibly preventive interventions--is on average applied more often to medicare beneficiaries than to the population as a whole.

o It is clear that medicare policies affect the adoption and use of medical technologies, and the patterns and levels of use of medical technologies significantly affect medicare costs.

o The passage of the new DRG payment system has further complicated the relationship between medicare and the health care technology industry. The old cost based reimbursement system put no pressure on hospital administrators to consider the cost effectiveness of a particular technology.

o Under the new DRG system hospitals will be pressuring physicians to utilize fewer less costly services. While this is a positive outcome in light of our cost concerns, in some cases, the substitution of low cost technolgoies for high-cost technologies may result in a decline in quality of care. Thus, quality of care remains an important issue under DRG payment.

5. The Future Under DRG's

o Innovations in medical devices, drugs, and medical techniques that raise the quality of care for the medicare population but also increase hospital per case costs may not be readily adopted unless DRG payment rates are updated.

o However, refinements and the development of some sort of severity index are anticipated as a result of the studies we mandated and the charge we gave to the Prospective Payment Assessment Commission to make recommendations on updating of the DRG's. The payment should be fair and represent our knowledge of changes in technology. But there will no longer be any blank checks. Costs will be our overwhelming concern.

o As you know both the Administration and the Prospective Payment Commission are currently reviewing the DRG rates with a view towards making their recommendations for the payment updating factors to be used for fiscal 1986. Also included in this review are questions about the need to possibly recalibrate the DRG's or rebase them. For example I know PROPAC has begun an indepth analysis of cardiac pacemaker implantation and intraocular lens implantation. Questions had been raised about the weights that had been determined for each. Input from your association and your individual companies will be critical to these efforts to keep the DRG's current, or to correct earlier mistakes.

o The Congress is not likely to want to get involved in making the specific determinations as to what therapy or treatment should be given a higher DRG weight under the system. They are however likely to get involved if the system fails to provide for appropriate changes given changes in the industry.

o Also critical to our attempts to make the system more equitable, will be efforts to develop a severity index, or some method of showing variations within DRG's. The Department of HHS has underway a number of studies looking at various methods. The winter issue of the Health Care Financing Review highlights some of these studies. While I am anxious to see the implementation of some form of severity index, it may take some time yet.

o It was not our intention to stifle innovation with the DRG's. We have the best health care delivery system in the world and want to keep it that way. But we can't afford to do so at any cost.

6. Capital Expenditures under Medicare

o How medicare reimburses for capital expenditures will also have a major impact on your industry. As you know a study of alternative means for reimbursing for capital was requested by the Congress. That study was due to the Congress this fall and has not yet been received. I have just written to the Secretary asking for the results of their work so we can begin our evalution of the options.

o Two possible alternatives to the current capital cost pass-through are to incorporate a flat rate for capital into the DRG rates or to build hospital-specific capital allowances into the DRG system. Although the flat rate approach is generally more efficient than pass through payments; it does raise questions of fairness among hospitals and equity of access to medical technologies among patients.

o The hospital specific option while improving upon the equity of the system, also builds in all of the inefficiencies of the past, rewarding those who have overcapitalized.

o We are all anxious to resolve the issue of capital as quickly as we can. I am hopeful that we will be able to do so before the end of the year. The Administration's proposals will certainly be the subject of Subcommittee hearings early in the new year.

7. Physician Reimbursement

o We have finally begun the process of reforming the way we pay physicians. Our primary concern, as it was with hospital reimbursement, was to reduce the growth in expenditures. Given the physicians control over the Health care system, clearly changes in physician payment methods will also influence physicians incentives for the use of medical technologies.

o We want to continue to insure that physicians are free to make the best decision for their patients but with some sense of a need for cost considerations.

o One change we are certainly likely to try and accomplish through our reform of the payment system, is to recognize more fairly the services provided by specialties like internal medicare and family practice. These groups have argued for sometime that the payment system rewards those who utilize more technology and procedures in their practices. For example, surgeons. This type of change will obviously have an impact on the reaction of physicians to new technologies. They will also become increasingly conscious of the cost benefit and cost effectiveness of certain technologies.

8. Conclusion

o There are problems pertaining to the administration of the medicare benefit coverage process that need attention including the inadequate identification of emerging and

outmoded technologies, along with questions about how best to make modifications in the DRG's to reflect these changes.

o In the past medicare has not explicitly considered cost or cost-effectiveness information in making coverage decisions. Medicare has also refrained from a policy of limiting coverage of a particular technology to restricted hospitals or physicians. My preference at the moment is to maintain medicare's current principle of refraining from interfering with medical practice and assuring beneficiares a free choice of providers. But this will become more difficult to do as time goes by if the costs of the program continue to escalate.

o In making any decisions, it will be important to keep in mind that medicare is only one of many public and private institutions that influence the development and diffusion of medical technology. You must work with all aspects of the system including the FDA, OTA and private insurers, in trying to sort out how we can best resolve these important issues.

o It will not be easy to determine what constitutes rational and appropriate adoption and use of medical technology from the perspective of the medicare program, society in general, and individual patients and providers, but keep in mind the Federal deficit will force some very difficult choices on us, as they will on the private sector. While we all want a quality health care system, we want it at a price we can afford.