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KEYNOTE SPEECH

THE GOVERNMENT RESEARCH CORPORATION'S
NINTH ANNUAL LEADERSHIP CONFERENCE

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MAYFLOWER HOTEL

I AM VERY PLEASED TO BE HERE TO SHARE WITH YOU MY VIEW OF WHAT THE KEY HEALTH CARE FINANCING ISSUES WILL BE DURING 1985. GOOD HEALTH IS A BLESSING, ONE WE HAVE COME TO EXPECT. IT IS ALSO A GOAL TO WHICH WE HAVE CONTRIBUTED ENORMOUS AMOUNTS OF OUR RESOURCES. 1985 AND THE YEARS BEYOND WILL SEE CONTINUED GROWTH IN TECHNOLOGY, AND FURTHER ADVANCES IN SCIENCE. BOTH OF WHICH WILL HEIGHTEN OUR CONCERNS ABOUT THE COSTS OF CARE AND THE ORGANIZATION OF OUR DELIVERY SYSTEMS. THESE CONCERNS WILL BE VOICED BY NOT ONLY GOVERNMENT BUT ALSO PRIVATE INDUSTRY, AND INDIVIDUAL CITIZENS NATIONWIDE.

CRITICAL TO OUR DISCUSSIONS ABOUT THE FUTURE SHOULD BE OUR BELIEF THAT THE COST OF HEALTH CARE SHOULD BE BORNE BY THE ENTIRE POPULATION THROUGH THE PRIVATE INSURANCE SYSTEM AND TAX-SUPPORTED GOVERNMENT PROGRAMS. NEITHER OF THOSE SYSTEMS ALONE, WHETHER THE GOVERNMENT OR THE PRIVATE SECTOR CAN BEAR THE ENTIRE BURDEN OF CARING FOR OUR CITIZENS. IT MUST BE A COOPERATIVE EFFORT.

WE HAVE, HOWEVER, STARTED THE PROCESS IN MOTION. THE COMMITTEE HAS BEEN IN DISCUSSION WITH THE INSTITUTE OF MEDICINE TO BE SURE THAT THE WORK THE INSTITUTE HAS UNDERTAKEN WITH RESPECT TO PHYSICIAN SERVICES HELPS TO MEET THE NEEDS OF THE COMMITTEE IN ITS CONSIDERATION OF PHYSICIAN PAYMENT REFORM. ADDITIONALLY, THE CONGRESS WILL ASK THE OFFICE OF TECHNOLOGY ASSESSMENT (OTA) TO ASSIST WITH A STUDY TO EXAMINE PROGRAM POLICY MODIFICATIONS DIRECTED AT ELIMINATING INEQUITIES IN PHYSICIAN PAYMENTS, INCREASING INCENTIVES FOR ASSIGNMENT, AND INFLUENCING UTILIZATION. OTA WILL ALSO BE ASKED TO ADVISE THE CONGRESS AS TO THE ADVISABILITY AND FEASIBILITY OF DEVELOPING FEE SCHEDULES OR OTHER PAYMENT METHODOLOGIES FOR PHYSICIAN SERVICES ON A NATIONAL OR REGIONAL BASIS.

AS YOU MAY KNOW, THE SECRETARY OF HEALTH AND HUMAN SERVICES HAS ALREADY BEEN CHARGED WITH REPORTING ON THE ADVISABILITY AND FEASIBILITY OF MAKING PAYMENTS FOR PHYSICIAN SERVICES FURNISHED TO HOSPITAL INPATIENTS ON A DRG-BASIS. THE CONGRESS WILL SOON ASK THAT THE SECRETARY ALSO DEVELOP CENTRALIZED DATABASES REGARDING UTILIZATION, ASSIGNMENT, AND REASONABLE CHARGE DISTRIBUTIONS BY SPECIALTIES AND LOCALITY, FOR PHYSICIAN SERVICES.

IT HAS BEEN SUGGESTED THAT IN 1985 WE PASS LEGISLATION REQUIRING THE SECRETARY TO CREATE A NEW PHYSICIAN PAYMENT SYSTEM ALONG THE LINES OF THE DRG-BASED PROPECTIVE SYSTEM ADOPTED FOR

INPATIENT HOSPITAL CARE. THAT WOULD BE AN EASY THING TO DO. IMPLEMENTATION HOWEVER WOULD NOT. IN FACT, IMPLEMENTATION OF A NATIONAL SYSTEM MIGHT WELL BE IMPOSSIBLE UNTIL THE DATA WAS AVAILABLE ON WHICH TO BASE SUCH A SYSTEM. AND EVEN THEN, THE DATA MAY INDICATE THAT WHAT HAD BEEN REQUIRED THROUGH LEGISLATION WAS THE WRONG THING TO DO.

TO MY MIND, I BELIEVE WE HAD BETTER WAIT UNTIL ALL THE CARDS ARE ON THE TABLE BEFORE WE START DEALING A HAND WHICH CAN'T BE PLAYED. LET'S SEE WHAT WE LEARN FROM THE EXPERTS--OTA, IOM, AND HHS BEFORE WE COMMIT OURSELVES.

THE ROLE OF THE BENEFICIARY

OVER 29 MILLION AMERICANS ARE ENROLLED AS BENEFICIARIES UNDER THE MEDICARE PROGRAM. THOSE INDIVIDUALS ARE THE THIRD, AND TO MY MIND, THE MOST IMPORTANT PARTY TO THE MEDICARE PROGRAM. ONE OUT OF FOUR OF THOSE INDIVIDUALS WILL NEED AND USE PART A SERVICES--INPATIENT HOSPITAL CARE FOR THE MOST PART, WHILE ALMOST 3 OF OUT OF FOUR WILL NEED AND USE PHYSICIAN AND OTHER RELATED HEALTHCARE SERVICES UNDER PART B OF THE PROGRAM.

WE HAVE NOT AS YET BEGAN TO CONSIDER IN GREAT EARNEST THE MODIFICATIONS IN ELIGIBILTY, BENEFITS AND COST SHARING THAT MAY BE NECESSARY, IN CONJUNCTION WITH OTHER CHANGES, TO BRING THE PROGRAM INTO ACTUARIAL BALANCE. WE HAVE HAD A GLIMPSE AT THE

KINDS OF THINGS THAT MIGHT BE PART OF A MEDICARE SOLVENCY PACKAGE. LEGISLATION HAS BEEN INTRODUCED OR PROPOSALS HAVE BEEN DISCUSSED IN COMMITTEE DEALING WITH EACH OF THESE ELEMENTS. TO DATE, ONE THING IS CERTAIN--IN WHATEVER WE DO THERE IS A REAL COMMITMENT TO PROTECT LOW INCOME BENEFICIARIES. I SHARE THAT COMMITMENT.

BUT WHAT ABOUT THE ELDERLY? HOW DO THEY SEE THE FINANCIAL CRISIS AS BEING SOLVED? WHAT PRIORITIES HAVE THEY SET? IT WILL COME AS NO SURPRISE IF I TELL YOU THAT REDUCED BENEFITS AND INCREASED COST SHARING RECEIVE THE LOWEST PRIORITY AMONG THE ELDERLY. A RECENT SURVEY HAS SHOWN THAT NATIONWIDE, CUTS IN PROGRAMS WHICH SERVE THE POOR AND THE ELDERLY, AND THE HIGH COST OF HEALTHCARE ARE THE TWO MOST IMPORTANT ISSUES FOR BOTH ADULTS OVER THE AGE OF 25 AND THOSE OVER 65. NEARLY THREE QUARTERS OF THOSE SURVEYED FAVORED LIMITING WHAT PROVIDERS ARE ALLOWED TO CHARGE. THEY ALSO BELIEVE THAT COST CONTROLS WOULD NOT CAUSE QUALITY TO SUFFER.

I DO NOT BELIEVE THAT SIMPLY RELYING ON COST CONTROLS AND LIMITS ALONE IS THE CORRECT SOLUTION. MANY STUDIES HAVE DEMONSTRATED THAT HEALTH SERVICES ARE MOST EFFECTIVE WHEN BOTH PROVIDERS AND CONSUMERS ARE LEAST MOTIVATED BY ECONOMIC CONSIDERATIONS. THIS MEANS THAT A PRACTITIONER OR INSTITUTION SHOULD BE FREE TO PERFORM OR REFUSE A SERVICE ACCORDING TO A

PATIENT'S NEEDS, RATHER THAN HIS OR SOMEONE ELSE'S WILLINGNESS OR UNWILLINGNESS TO PAY FOR THOSE SERVICES.

I CONTINUE TO BELIEVE THAT PROGRAM BENEFICIARIES--IN FACT, ALL PATENTS--MUST ASSUME SOME RESPONSIBILITY FOR CONTROLLING COSTS. A MAJORITY OF THE ELDERLY IN THE SURVEY I MENTIONED INDICATED THAT THEY WOULD MAKE A CHOICE AS TO WHERE TO RECEIVE MEDICAL TREATMENT BASED ON THE COST OF THAT TREATMENT. I DO BELIEVE THAT COST, IMPOSED ON THE CONSUMER, CAN AND SHOULD PLAY A ROLE IN CONTROLLING UTILIZATION.

COMING TO GRIPS WITH THE MEDICARE SOLVENCY ISSUE WILL NOT BE EASY. THERE IS NO "SNAP OF THE FINGERS" SOLUTION. PAYMENT LIMITS CAN ONLY GO SO FAR BEFORE QUALITY AND ACCESS TO CARE BEGIN TO SUFFER. THE SOLUTION WILL MORE THAN LIKELY REQUIRE A MIX AND BLENDING OF MANY THINGS AND THE INVOLVEMENT OF ALL PARTIES TO THE PROGRAM--HOSPITALS, DOCTORS, PATIENTS, AND TAXPAYERS.

LONG-TERM CARE SERVICES

FOR THE FUTURE, THE PROSPECTS OF LONGER LIFE WILL SPARK A REVOLUTION IN THE HEALTH CARE INDUSTRY THAT WILL PALE IN COMPARISON TO WHAT WE HAVE SEEN SINCE THE PASSAGE OF MEDICARE AND MEDICAID.

AND OTHER PROGRAMS. WITH THAT IN MIND, WE MUST BEGIN TO CONSIDER HOW BEST TO UTILIZE THE FEDERAL DOLLARS AVAILABLE AND TO WHAT EXTENT THE INDIVIDUAL STATES MUST SHOULDER RESPONSIBILITY FOR THE NATION'S ECONOMICALLY DISADVANTAGED.

RECOGNIZING THAT MEDICAID ELIGIBILITY IS ONLY EXTENDED TO SPECIFIC GROUPS, THE SUBCOMMITTEE ON HEALTH HAS BEGUN A SERIES OF HEARINGS TO IDENTIFY THE NATION'S ECONOMICALLY DISADVANTAGED, THE EXTENT TO WHICH THEY ARE CURRENTLY PROVIDED HEALTHCARE SERVICES, AND THE DELIVERY SYSTEMS AND FINANCING MECHANISIMS USED TO PROVIDE THAT CARE. ONCE THE SIZE AND SCOPE OF THE UNMET HEALTHCARE NEEDS OF THE ECONOMICALLY DISADVANTAGED ARE DEFINED, CONSIDERATION MUST BE GIVEN TO WHOSE RESPONSIBILITY IT SHOULD BE TO MEET THOSE NEEDS.

CONCLUSION

IN REFLECTING BACK ON WHAT I HAVE SAID, YOU CANNOT HELP BUT NOTICE A GREAT DEAL OF EMPHASIS ON FEDERAL PROGRAMS. UNDERSTANDABLY WHEN IT COMES TO HEALTHCARE WE SPEND A GREAT DEAL OF TIME FOCUSING OUR ATTENTION ON MEDICARE AND MEDICAID. NEEDLESS TO SAY THE FEDERAL GOVERNMENT IS NOT THE ONLY THIRD PARTY PAYOR IN TOWN. THE PRIVATE SECTOR FOOTS A GREAT DEAL OF THIS NATION'S HEALTHCARE BILL. WHAT HAPPENS WHEN GENERAL MOTORS ESTABLISHES A NEW HEALTH BENEFIT PACKAGE FOR ITS EMPLOYEES, WHEN AETNA IMPLEMENTS A MEDICAL REVIEW POLICY TO SUBSTITUTE LOWER COST

HOME HEALTH CARE FOR INSTITUTIONAL CARE, OR KIMBERLY-CLARK ADOPTS A PHYSICAL FITNESS PROGRAM FOR ITS EMPLOYEES HAS A GREAT DEAL TO DO WITH DETERMINING HOW MUCH WE AS A NATION ULTIMATELY PAY FOR HEALTHCARE. CORPORATE AMERICA HAS BEEN ON THE CUTTING EDGE OF INNOVATION WHEN IT COMES TO MORE EFFICIENT AND EFFECTIVE HEALTHCARE DELIVERY SYSTEMS. I HOPE THAT CONTINUES TO BE THE CASE.

FOR THE FEDERAL SECTOR, AS I HAVE MENTIONED THE CHALLENGES ARE MANY BUT I BELIEVE WE CAN ACHIEVE WHATEVER GOALS WE SET FOR OURSELVES. HEALTH CARE WILL CONTINUE TO BE A BLESSING, BUT ONLY IF WE CEASE TO TAKE IT FOR GRANTED.

BUT BEFORE WE GET TO 1985 WE MUST FIRST COMPLETE OUR WORK IN 1984, WHICH MEANS COMPLETION OF THE DEFICIT REDUCTION ACT.

DEFICIT REDUCTION

TREMENDOUS PROGRESS HAS BEEN MADE IN RESOLVING OUR DIFFERENCES WITH THE HOUSE OVER THE TAX ITEMS. AS OF LAST FRIDAY AFTERNOON, APPROXIMATELY $40 BILLION IN REVENUES HAD BEEN AGREED TO BY THE CONFEREES.

OUR DISCUSSIONS ON THE SPENDING REDUCTION PROVISIONS ARE SCHEDULED TO BEGIN TOMORROW MORNING AND ARE LIKELY TO BE QUITE CONTENTIOUS IN A NUMBER OF AREAS. HOWEVER I BELIEVE WE WILL REACH AGREEMENT ON MANY ITEMS AND, HOPEFULLY, ACHIEVE SAVINGS IN THE RANGE OF $5-7 BILLION.

MEDICARE PROVISIONS IN CONTROVERSY

YOU ARE ALL WELL ACQUAINTED WITH THE MEDICARE PROVISIONS CONTAINED IN BOTH THE HOUSE AND SENATE BILLS. WE ARE AGAIN FACED WITH A SITUATION WHERE THE SENATE AMENDMENTS CONTAIN SUBSTANTIAL SAVINGS IN MEDICARE AS COMPARED TO THE HOUSE. CLEARLY, THE PHYSICIAN PAYMENT FREEZE AND THE BENEFICIARY REDUCTIONS WILL RECEIVE THE LARGEST SHARE OF THE ATTENTION OF THE CONFEREES.

1. COST SHARING

THE TWO MOST SIGNIFICANT BENEFICIARY COST SHARING CHANGES ARE REALLY RATHER SMALL IN THE OVERALL CONTEXT OF THE PROGRAM. WITH RESPECT TO THE PART B PREMIUM OF COURSE, WE SIMPLY CONTINUE PRESENT POLICY.

IN PERMITTING INDEXING OF THE PART B DEDUCTIBLE, WE ARE MERELY TRYING TO INSURE THAT THE DEDUCTIBLE SIMILAR TO THE DEDUCTIBLE FOR PART A, CHANGES TO REFLECT INCREASING PROGRAM COSTS.

WHILE IT IS ESTIMATED THAT THE ELDERLY WILL HAVE TO SPEND THE SAME PERCENT OF THEIR INCOME ON HEALTH CARE IN 1984 AS THEY HAD TO SPEND BEFORE MEDICARE WAS FULLY OPERATIONAL, WE SHOULD KEEP IN MIND THE TREMENDOUS RANGE AND INTENSITY OF SERVICES MADE AVAILABLE BY THE PROGRAM TO THE ELDERLY TODAY AS COMPARED TO 18 YEARS AGO. WITHOUT BEING REQUIRED TO SPEND ANY GREATER PORTION OF THEIR INCOME, THE ELDERLY NOW AVAIL THEMSELVES OF KIDNEY DIALYSIS, ARTIFICIAL JOINTS, CARDIAC PACEMAKERS, CORONARY BYPASSES, AND NUMEROUS OTHER MEDICAL PROCEDURES AND TECHNOLOGIES WHICH RESTORE FUNCTIONAL CAPABILITY AND EXTEND LIFE. AS A RESULT, THE ELDERLY ARE HEALTHIER TODAY AND RECEIVE BETTER CARE THAN THEY DID IN 1966, AT NO GREATER COST BURDEN TO THEMSELVES.

PHYSICIANS MUST BE BROUGHT INTO THE PICTURE OF COST CONTAINMENT. MANY MODES OF PRACTICE ARE ALREADY IN PLACE--PREPAID GROUP PRACTICE, INDEPENDENT PRACTICE ASSOCIATIONS, PRIMARY CARE NETWORKS AND TRADITIONAL FEE FOR SERVICE PRACTICES. EACH OF WHICH OFFERS DIFFERENT ANSWERS TO THE QUESTIONS ABOUT THE UTILIZATION OF SERVICES AND COSTS. THE SENATE AMENDMENT DOES NOT PRETEND TO ANSWER ALL OF THE ISSUES BEFORE US. IT SIMPLY TRYS TO TEST FOR A LIMITED TIME, ONE OR TWO THEORIES, IN THE HOPE THAT WE WILL DO A BETTER JOB OF DESIGNING A SYSTEM FOR THE LONG-TERM.

FUTURE DIRECTIONS

SOME OF YOU MAY RECALL THAT IN 1927, A NATIONAL COMMITTEE ON THE COSTS OF MEDICAL CARE BEGAN A FIVE-YEAR STUDY OF THE PROVISION AND FINANCING OF HEALTH SERVICES FOR THE AMERICAN PEOPLE. EVEN AT THAT TIME THERE WAS WIDESPREAD CRITICISM OF PRICES FOR HEALTH SERVICES IN ADDITION TO A GENERAL BELIEF THAT SERVICES WERE NOT READILY AVAILABLE TO THE COMMON MAN OR WOMAN.

THE FINAL REPORT OF THE COMMITTEE DOCUMENTED THE FACT THAT NO ONE COULD TELL WHEN HE WOULD BE SICK OR DISABLED, OR HOW MUCH HEALTH CARE WOULD COST. SOME RECEIVED NO SERVICES IN A YEAR. OTHERS FACED EXPENDITURES OF SEVERAL THOUSAND DOLLARS. THIS UNCERTAINTY ABOUT EXPOSURE TO RISK, AND THE SIZE OF THE RISK IS WHAT LED TO MUCH OF THE CRITICISM OF THE DAY.

HEALTH CARE CONTINUES TO BE FRAUGHT WITH UNCERTAINTY. HEALTH CARE IS ALSO UNIQUELY PERSONAL. WE'VE ALL EXPERIENCED A FRANTIC PARENT WITH A SICK CHILD, OR AN ADULT DAUGHTER OR SON WITH AN ILL PARENT. IN EACH SITUATION THE DESIRE IS TO PROVIDE WHATEVER IS NECESSARY, WHATEVER THE COST. IN LOOKING TO THE FUTURE WE MUST BE PREPARED TO DEAL WITH THESE ISSUES IN A FORTHRIGHT MANNER. A REFUSAL TO DISCUSS OR CONSIDER THE TRADEOFFS IN HIGHER COST SHARING FOR THE CERTAINTY OF CATASTROPHIC COVERAGE IS ONE EXAMPLE OF A SHORT SIGHTED VIEW OF THE FUTURE.

PARTICULARLY WITH RESPECT TO PROGRAMS LIKE MEDICARE AND MEDICAID, THE ISSUES WILL NOT BE EASY. BUT ADDRESS THEM WE MUST.

WHAT THE FUTURE HOLDS FOR THE MEDICARE AND MEDICAID PROGRAMS IS LARGELY A FUNCTION OF TWO FACTORS--DEMOGRAPHICS AND FINANCING. THE DEMOGRAPHICS OF THE FUTURE WILL PLACE EVER MORE INCREASING DEMANDS ON THE NATION'S HEALTHCARE SYSTEM AS THE ELDERLY SEGMENT OF THE POPULATION EXPANDS.

IN CONCERT WITH THE GROWING NEED FOR HEALTHCARE SERVICES, THE FUTURE WILL BRING EVER INCREASING STRAINS ON OUR CAPABILITY TO FINANCE THAT NEEDED CARE. INDEED, WE DON'T HAVE TO WAIT FOR THE FUTURE TO SEE THE STRAIN. FOR SOME TIME NOW WE HAVE BEEN ALERT TO THE COMING FINANCIAL CRISIS IN THE MEDICARE PROGRAM. AND FOR SOME TIME WE HAVE BEEN PREPARING TO DEAL WITH THAT CRISIS. FOR HOSPITALS, WE HAVE MOVED AWAY FROM THE SPIRALLING COST INCENTIVES WHICH WERE PRESENT UNDER COST REIMBURSEMENT. NO LONGER DO WE ALLOW HOSPITALS TO PASS ALONG TO MEDICARE EVER INCREASING COSTS. INSTEAD, WE HAVE SET THE PRICES WE WILL PAY FOR SERVICES IN ADVANCE THEREBY PROVIDING HOSPITALS WITH AN INCENTIVE TO HOLD COSTS IN CHECK. THE NEW SYSTEM IS NOT PERFECT. THERE ARE STILL SOME GROWING PAINS WHICH WE HAVE BEEN MAKING EVERY EFFORT TO ADDRESS WITHOUT VIOLATING THE CONCEPT AND INTEGRITY OF THE NEW SYSTEM.

HOW WELL THE NEW PROSPECTIVE PAYMENT SYSTEM DOES IN HOLDING DOWN THE COST OF INPATIENT CARE IS A QUESTION YET TO BE ANSWERED. AS YET, NOT ALL HOSPITALS ARE OPERATING UNDER THE PROSPECTIVE PAYMENT SYSTEM BECAUSE IT IS SO NEW.

"THE YEAR OF THE PHYSICIAN"

BUT WHAT ABOUT THE OTHER PARTICIPANTS IN THE MEDICARE PROGRAM? AS YOU REMEMBER, I INDICATED SOME TIME AGO THAT WE WOULD BEGIN TO ADDRESS THE RISING COSTS OF PHYSICIAN SERVICES. THE "YEAR OF THE PHYSICIAN", AS I HAD CALLED IT, HAS NOT AS YET COME TO PASS. BUT IT IS NOT BECAUSE WE HAVE LOST INTEREST. THE FACT OF THE MATTER IS THAT THERE IS VERY LITTLE INFORMATION AVAILABLE ON WHICH TO BASE OR IMPLEMENT POLICY DECISIONS WITH RESPECT TO PHYSICIAN REIMBURSEMENT.