SENATOR BOB DOLE
NATIONAL HEALTH COUNCIL
30TH ANNUAL MEETING
THURSDAY, SEPTEMBER 30, 1982

RECENT YEARS HAVE WITNESSED NUMEROUS BATTLES FOR CONTROL WITHIN AND BETWEEN HEALTH CARE INSTITUTIONS AND HEALTH CARE PROFESSIONALS. THESE BATTLES ARE LIKELY TO CONTINUE AS OUR RESOURCES FOR HEALTH SERVICES CONTINUE TO SHRINK.

THE EXTRAORDINARY RATE OF GROWTH IN FEDERAL HEALTH CARE EXPENDITURES HAS FORCED A REEXAMINATION OF NOT ONLY WHAT SERVICES THE FEDERAL GOVERNMENT PAYS FOR, BUT ALSO THE WAY WE PAY FOR THEM, AND THE PROVIDERS WE REIMBURSE.

I. THE ISSUES

COST OF CARE

THE MOST NOTABLE ASPECT OF HEALTH CARE SPENDING HAS BEEN ITS RAPID, SUSTAINED RATE OF GROWTH. THE 15.1 PERCENT RATE OF INCREASE IN OVERALL HEALTH EXPENDITURES IN 1981, ALONG WITH THE 15.8 PERCENT RATE OF GROWTH IN 1980, ARE THE HIGHEST IN THE LAST 15 YEARS, AND ARE SUBSTANTIALLY ABOVE THE AVERAGE GROWTH RATE BETWEEN 1976 AND 1981.

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 THAT RECOGNITION HAS NOT BROUGHT ABOUT AGREEMENT ON THE SOLUTION. 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 FUND, THEREBY FORCING US TO MAKE DECISIONS ON SPENDING PRIORITIES.

MEDICARE GOING BROKE

BASED ON THE MOST RECENT ESTIMATES BY THE SOCIAL SECURITY ACTUARIES, THE MEDICARE HOSPITAL INSURANCE TRUST FUND COULD BE BROKE AS EARLY AS THE END OF THE DECADE, PERHAPS EVEN EARLIER DEPENDENT ON OUR DECISIONS WITH RESPECT TO THE FINANCING OF THE SOCIAL SECURITY CASH PROGRAM. THE ONLY REAL SOLUTIONS FOR MEDICARE SEEM TO INVOLVE INCREASING INCOME, DECREASING EXPENDITURES, OR BOTH.

PRACTICAL POLITICS HAS INFLUENCED WHAT WE HAVE DONE TO DATE TO SLOW THE RATE OF GROWTH IN THIS PROGRAM. MEDICARE IS AN ENTITLEMENT PROGRAM, OBLIGATED TO PAY FOR COVERED SERVICES USED BY ELIGIBLE PERSONS. FEDERAL FUNDS ARE PERMANENTLY OBLIGATED FOR THIS PURPOSE. VOCAL, POWERFUL CONSTITUENCIES HAVE RESISTED MOST CHANGES IN THIS PROGRAM, MAKING SPENDING CUTS VERY DIFFICULT TO MAKE. BUT CHANGES HAVE BEEN MADE, AND THEY ARE LIKELY TO CONTINUE. CHANGES, I REMIND YOU, THAT ARE NECESSARY TO SECURE THE LONG TERM SURVIVAL OF THE MEDICARE PROGRAM.

MEDICAID ALSO OF CONCERN

ON THE MEDICAID SIDE, COSTS ARE ALSO OF SERIOUS CONCERN TO BOTH THE STATES AND THE FEDERAL GOVERNMENT. THE RATE OF GROWTH IN THIS PROGRAM IS SLOWER, BUT STEADY.

DESIGNING SOLUTIONS TO THE COST PROBLEMS FACED BY THIS PROGRAM ARE SOMEWHAT MORE DIFFICULT BECAUSE OF THE SHARED FINANCIAL RESPONSIBILITY HELD BY THE STATES AND THE FEDERAL GOVERNMENT.

IT IS FAIR TO SAY THAT THE ADMINISTRATION'S ACTIONS TOWARD MEDICAID REFLECT A DESIRE TO REDUCE FEDERAL SPENDING AND TO INCREASE STATE RESPONSIBILITY AND FLEXIBILITY IN THE DESIGN AND ADMINISTRATION OF THEIR PROGRAMS. WE SHOULD NOT AGREE, NOR DO I BELIEVE THAT THE CONGRESS HAS AGREED, TO CUTS THAT ARE SIMPLY A DECREASE IN FEDERAL SPENDING WITHOUT AT THE SAME TIME, AN INCREASE IN STATE FLEXIBILITY.

ITS IMPORTANT TO REMEMBER THAT IN MAKING CHANGES IN THEIR PROGRAMS, STATES ARE RESPONDING TO NOT ONLY CHANGES IN FEDERAL SPENDING PRIORITIES, BUT ALSO TO INTERNAL FISCAL AND POLITICAL CONCERNS. POLICY CHANGES IN THE STATES ARE FOCUSING ON ELIGIBILITY, REIMBURSEMENT, AND THE SCOPE OF BENEFITS. WHILE SOME OF THE CHANGES MAY INVOLVE A SHIFTING OF PRIORITIES WITH RESPECT TO BENEFITS AND ELIGIBLE POPULATIONS, OTHER CHANGES MAY

RESULT IN INCREASED ACCESS TO COMMUNITY BASED SERVICES AND HOME CARE. WHAT I MEAN TO SUGGEST IS THAT CHANGE IS NOT ALWAYS BAD. THE STATES, IN BEING FORCED TO REEXAMINE THEIR PROGRAMS AND REESTABLSH THEIR PRIORITIES, CAN BE EXPECTED TO IMPROVE THEIR PROGRAMS. FISCAL CONSTRAINTS FORCE US TO LOOK FOR LESS EXPENSIVE WAYS OF DOING THINGS. IN HEALTH CARE THIS MAY RESULT IN A SHIFT FROM INSTITUTIONAL CARE TO NONINSTITUTIONAL CARE; A GOAL I BELIEVE MANY OF US WOULD SUPPORT.

AS WITH MEDICARE, CHANGES IN MEDICAID ARE LIKELY TO CONTINUE BECAUSE OF OUR CONCERN WITH RESPECT TO INCREASING COSTS. COMPLICATING THIS DISCUSSION WILL BE OUR DELIBERATIONS ON NEW FEDERALISM.

PAYMENT SYSTEMS

TO DATE, HOSPITALS HAVE BEEN THE MAJOR FOCUS OF CONCERN REGARDING THE COST OF CARE. THIS IS TRUE OF BOTH THE PUBLIC SECTOR FINANCING PROGRAMS AND THE PRIVATE SECTOR SYSTEM. I SUSPECT THEY WILL CONTINUE TO BE THE FOCUS FOR SOME TIME TO COME. EFFORTS TO CHANGE THE WAY WE DEAL WITH HOSPITALS AND HOW THEY DO THEIR BUSINESS HAVE BEEN INITIATED BY THE LAST TWO ADMINISTRATIONS. THE CONGRESS HAS ALSO BEEN INTIMATELY INVOLVED IN THIS ISSUE, AND IN FACT IS RESPONSIBLE FOR ONE OF THE MOST IMPORTANT PROVISIONS INCLUDED IN THIS YEAR'S TAX EQUITY AND FISCAL RESPONSIBILITY ACT.

HOSPITAL REIMBURSEMENT

THE PROVISION I'M REFERRING TO IS THE ONE WHICH EXPANDS THE SECTION 223 SYSTEM OF REIMBURSEMENT TO COVER ANCILLARY COSTS; PLACES AN OVERALL RATE INCREASE LIMIT ON MEDICARE PAYMENTS TO HOSPITALS; CREATES A SYSTEM OF INCENTIVE PAYMENTS FOR GOOD, COST-EFFICIENT BEHAVIOR; AND CLEARLY MOVES US TOWARDS THE DAY WHEN WE CAN PUT A PROSPECTIVE PAYMENT SYSTEM INTO PLACE.

THEORIES EXPLAINING HOSPITAL COST INCREASES

SEVERAL DIFFERENT THEORIES HAVE BEEN SUGGESTED TO EXPLAIN THE RAPID INCREASES IN HOSPITAL COSTS OVER THE YEARS.

SOME HAVE ARGUED THAT RISING COSTS ARE ATTRIBUTABLE TO INCREASES IN THE DEMAND FOR HOSPITAL CARE AND TO THE RESPONSE BY HOSPITALS TO THIS DEMAND. THOSE WHO SUPPORT THIS THEORY POINT OUT THE ROLE OF THIRD PARTY PAYERS WHO FINANCE THE OVERWHELMING PROPORTION OF CARE RENDERED IN HOSPITALS. AS A RESULT, EACH PATIENT HAS VERY LIMITED OUT OF POCKET COST, MAKING HIM LESS CONSCIOUS OF THE NEED TO BE CAUTIOUS ABOUT UTILIZATION.

THE SECOND THEORY FOCUSES ATTENTION ON THE METHOD OF REIMBURSEMENT UTILIZED FOR HOSPITALS. GENERALLY HOSPITALS ARE PAID ON THE BASIS OF THE COSTS THEY INCUR FOR THE DELIVERY OF SERVICES OR ON THE BASIS OF CHARGES. NEITHER METHOD PROVIDES ANY

INCENTIVES TO THE HOSPITAL TO CONTROL ITS COSTS. COMPOUNDING THIS PROBLEM IS THE FACT THAT REIMBURSEMENT IS GENERALLY RESTROSPECTIVE. MANY OF US BELIEVE THAT COSTS WILL CONTINUE TO BE DIFFICULT TO CONTROL UNTIL WE FINALLY MOVE AWAY FROM THIS SYSTEM.

A THIRD THEORY BLAMES WASTEFUL CAPITAL EXPENDITURES AND CERTAIN ADVANCES IN MEDICAL THECHNOLOGY FOR ESCALATING COSTS AND A FOURTH THEORY SINGLES OUT LABOR COSTS.

THE PROVISION AGREED TO THIS YEAR BEGINS TO ADDRESS THE SECOND THEORY. BUT REST ASSURED THE OTHER THREE THEORIES WILL BE ADDRESSED. WHICH BRINGS ME TO A DISCUSSION OF THE FUTURE.

II. FUTURE ISSUES

PROSPECTIVE PAYMENT

OBVIOUSLY, CONTINUED WORK ON HOSPITAL REIMBURSEMENT WILL BE NECESSARY. WE HAVE BEGUN OUR DISCUSSIONS WITH THE ADMINISTRATION ON A PROSPECTIVE PAYMENT SYSTEM AND FULLY EXPECT TO BEGIN WORK IN THE COMMITTEE EARLY IN THE NEW YEAR.

A RECENT SURVEY INDICATES THAT HOSPITALS ARE READY TO ACCEPT A PROSPECTIVE SYSTEM, EVEN THOUGH IT PUTS THEM AT GREATER

FINANCIAL RISK. THEY BELIEVE SUCH A SYSTEM WOULD HAVE BUILT-IN INCENTIVES FOR EFFICIENCY, WHICH ARE WORTH THE RISK.

INCENTIVES FOR EFFICIENCY IS ANOTHER WAY OF SAYING PROFITS--THE DIFFERENCE BETWEEN THE COST OF A HOSPITAL'S SERVICES AND WHAT THE GOVERNMENT WILL PAY. ESTABLISHING THE LATTER PRESENTS A FORMIDABLE PROBLEM.

QUESTIONS ABOUT PROSPECTIVE PAYMENT

HOW DO WE DECIDE WHAT SHOULD BE PAID FOR HOSPITAL SERVICES? AND SHOULD THOSE PAYMENTS VARY FROM HOSPITAL TO HOSPITAL?

PROSPECTIVE RATES CAN BE NEGOTIATED. IF THEY ARE, DOES THE GOVERNMENT USE ITS MARKET SHARE AS A LEVER TO EXTRACT THE LOWEST RATE? CERTAINLY THAT IS IN KEEPING WITH COMPETITION AND THE WAY AMERICAN BUSINESS CONDUCTS ITS AFFAIRS. BUT WILL THE HEALTH CARE INDUSTRY, THE PUBLIC, OR THE CONGRESS ALLOW NEGOTIATIONS ON SUCH A BASIS?

IS IT GOOD PUBLIC POLICY TO ALLOW NEGOTIATIONS WHICH RESULT IN RATES WHICH SHIFT COSTS TO ALL OTHER BUYERS OF HOSPITAL SERVICES?

PROSPECTIVE RATES CAN ALSO BE BASED ON COSTS. IF A HOSPITAL SERVICE CURRENTLY COSTS $100 TO PROVIDE, THAT AMOUNT CAN BE INCREASED TO ACCOUNT FOR EXPECTED INFLATION AND FOR REASONABLE PROFITS--THE BUILT-IN INCENTIVE. BEFORE SETTING PROSPECTIVE RATES BASED ON COSTS, HOWEVER, SHOULD THE GOVERNMENT FIRST DECIDE WHETHER THOSE COSTS ARE REASONABLE? IS $3,895 THE "REASONABLE" COST OF A CARDIAC PACEMAKER, IF AS ALLEGED, THAT COST INCLUDES CASH KICKBACKS, SKI VACATIONS, AND THE COSTS OF OTHER SO-CALLED MARKETING STRATEGIES ON THE PART OF THE SUPPLIER? WHAT ABOUT CAPITAL COSTS, BAD DEBTS, AND ALL THE OTHER ITEMS THAT HAVE BEEN AND ARE CURRENTLY ISSUES IN ESTABLISHING REASONABLE COSTS FOR MEDICARE REIMBURSEMENT?

ONCE COSTS ARE ESTABLISHED, HOW DO WE ACCOUNT FOR INFLATION? IF WE PREDICT A RATE, WILL HOSPITALS BE WILLING TO ACCEPT THE FINANCIAL RISK INVOLVED WHEN INFLATION SURPASSES THE PREDICTION? IS A RETROSPECTIVE ADJUSTMENT ANY SOLUTION IF SUCH AN ADJUSTMENT IS PART OF A SELF-FULLFILLING PROPHECY?

AND THE ULTIMATE ISSUE: WHAT IS A REASONABLE PROFIT? IS IT AN INDUSTRY WIDE, REGIONAL, OR PEER GROUP AVERAGE? DOES IT DIFFER FOR PROFIT VS. NON-PROFIT HOSPITALS?

THERE ARE SOME POTENTIALLY SERIOUS PROBLEMS WITH SETTING A PROSPECTIVE RATE, BUT ONCE SET THERE ARE OTHERS TO BE ADDRESSED.

ENSURING THE QUALITY OF CARE PROVIDED UNDER A PROSPECTIVE RATE IS ESSENTIAL. BY THEIR VERY NATURE, PROSPECTIVE RATES OFFER AN INCENTIVE TO REDUCE COSTS AND THAT CAN ALL TOO EASILY TRANSLATE INTO REDUCED QUALITY.

PROSPECTIVE NOT EASY

PROSPECTIVE REIMBURSEMENT IS NOT THE "SNAP OF THE FINGERS" SOLUTION SOME EXPECT IT TO BE. BUT, WITH THE NECESSARY EFFORT IT CAN, I BELIEVE, PROVIDE A SOLUTION TO A GREAT MANY OF THE PROBLEMS EMBODIED IN THE CURRENT RETROSPECTIVE SYSTEM OF COST REIMBURSEMENT. MORE IMPORTANTLY IT CAN PROVIDE AT LEAST A PARTIAL SOLUTION TO THE FINANCIAL CRISIS FACING THE MEDICARE TRUST FUNDS.

PHYSICIAN REIMBURSMENT

THERE WAS LITTLE IN THE WAY OF CHANGE IN THIS YEAR'S BUDGET BILL IN THE METHODS WE GENERALLY USE TO REIMBURSE PHYSICIANS UNDER THE MEDICARE PROGRAM. HOWEVER, THIS IS NO INDICATION OF A LACK OF INTEREST ON OUR PART IN REFORM.

INCENTIVES TO ENCOURAGE MORE EFFICIENT USE OF SERVICES ARE AS IMPORTANT TO PHYSICIANS AS THEY ARE TO HOSPITALS. IN FACT THEY ARE PERHAPS EVEN MORE VITAL AS LONG AS THE PHYSICIAN REMAINS THE PRIMARY ENTRY POINT AND PRESCRIBER OF HEALTH CARE SERVICES.

DURING FLOOR DEBATE ON THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982, I MADE IT CLEAR THAT WE WOULD DEVOTE TIME EARLY IN THE NEXT CONGRESS TO EXAMINING PHYSICIAN REIMBURSEMENT, AND PHYSICIAN ASSIGNMENT PATTERNS.

I FULLY EXCEPT THIS TO TAKE PLACE. PHYSICIANS, ALONG WITH EVERYONE ELSE, MUST DO THEIR PART TO HELP US REDUCE COSTS AND INCREASE EFFICIENCY IN THE MEDICARE SYSTEM.

OVERALL MEDICARE PROGRAM REFORM

AS I NOTED AT THE OUTSET, THE MEDICARE TRUST FUNDS ARE IN SERIOUS TROUBLE. ONLY TRUE SYSTEM WIDE REFORM WILL SAVE IT IN THE LONG RUN. AND BY REFORM, I DON'T SIMPLY MEAN INCREASING THE TAX THAT PAYS FOR MEDICARE.

COST SHARING; THE STRUCTURE OF BENEFITS; REIMBURSEMENT METHODOLOGY; PROVIDER STATUS, ARE ALL AREAS THAT MUST BE EXAMINED. FOR EXAMPLE, SOME OF THIS YEARS DISCUSSIONS ON MEDICARE VOUCHERS MAY BE REPEATED, AND NEW RECOMMENDATIONS CONSIDERED.

FULL PARTICIPATION IN THESE DELIBERATIONS BY THE INDUSTRY, AGING GROUPS, CONSUMERS, THE ADMINISTRATION AND THE CONGRESS WILL HELP MOVE TOWARDS REASONABLE SOLUTIONS. WHAT WON'T HELP IS THE IMMEDIATE REJECTION OF ANY CHANGE IN THE STATUS QUO. CHANGE IS COMING, MAKE NO MISTAKE. I FOR ONE BELIEVE WE MUST

MAINTAIN AND STRENTHEN MEDICARE. OUR FAILURE TO CONSIDER REASONABLE REFORM WOULD BE DISASTROUS FOR THE PROGRAM IN THE LONG RUN.

MEDICAID

IN THE AREA OF MEDICAID, I EXPECT FURTHER CONSIDERATION OF STATE REQUESTS FOR FLEXIBILITY. ATTENTION WILL ALSO BE GIVEN TO THE IMPLEMENTATION OF THE 1981 AND 1982 CHANGES IN THE HOPES OF ASSISTING THE STATES. OF COURSE, I AM SURE THERE WILL BE A SPIRITED DISCUSSION ON THE LARGER ISSUE OF WHETHER THE PROGRAM SHOULD BE FEDERALIZED. DISCUSSIONS HAVE BEEN TAKING PLACE BETWEEN THE GOVERNORS AND THE WHITE HOUSE OVER THE LAST FEW MONTHS. I AM ANXIOUS TO LEARN THE RESULTS OF THEIR WORK. HOWEVER, THE MASSIVE RESHUFFLING OF MEDICAID AND OTHER MAJOR PROGRAMS IS A COMPLEX UNDERTAKING, ONE THAT COULD PRODUCE SOME PITFALLS. IT IS VITAL THAT ANY REORGANIZATION OF MAJOR PROGRAMS GUARANTEES THAT NEEDY AMERICANS CONTINUE TO RECEIVE ESSENTIAL SERVICES AND ASSISTANCE. NEEDLESS TO SAY ONE OF THE BIGGEST QUESTIONS REMAINING IS THE FINANCING OF LONGTERM CARE. THE SOLUTION WILL NOT BE AN EASY ONE.

CONCLUSION

I LOOK FORWARD TO WORKING WITH ALL OF YOU IN MEETING THE CHALLENGES THAT FACE US. AS I NOTED EARLIER, CHANGE IS COMING. I CONTINUE TO BELIEVE THAT THE PRIVATE SECTOR SOLUTIONS TO OUR PROBLEMS ARE PREFERABLE TO FEDERAL INTERVENTION. HELP TO PROVE ME CORRECT.