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COMMENTS BY SENATOR BOB DOLE

BEFORE THE

NATIONAL ASSOCIATION FOR HOME CARE

MONDAY, MARCH 14, 1983

I'M PLEASED TO BE ABLE TO JOIN YOU TODAY. I'D LIKE TO SPEND MY BRIEF TIME WITH YOU LOOKING AT THE ROLE HOME CARE PLAYS IN DETERMINING THE HEALTH STATUS OF OUR CITIZENS, HOW HOME HEALTH CARE RELATES TO OUR FEDERAL HEALTH FINANCING PROGRAMS--SPECIFICALLY MEDICARE AND MEDICAID, AND WHAT THE OUTLOOK FOR LEGISLATIVE ACTION ON THE SUBJECT OF HOME HEALTH CARE IS.

THE NEED FOR HOME HEALTH CARE

I BELIEVE THE NUMBER AND RANGE OF PEOPLE WHO ARE PRESENT AT THIS CONFERENCE TODAY ATTEST TO THE FACT THAT THERE IS A GROWING CONSENSUS THAT HOME HEALTH CARE SHOULD PLAY A MORE CENTRAL ROLE IN THE HEALTH CARE DELIVERY SYSTEM, AND IN PROMOTING INDIVIDUAL WELL-BEING. SOME OF YOU HAVE PROBABLY HEARD ME BEFORE STRESS HOW IMPORTANT I BELIEVE IT IS FOR A PERSON TO ADOPT PREVENTIVE MEASURES FOR MAINTAINING OR IMPROVING HIS OR HER HEALTH STATUS. THE RESPONSIBILITY FOR GOOD PERSONAL HEALTH RESTS FIRST AND FOREMOST WITH THE INDIVIDUAL. AND YET, I THINK WE ALL KNOW THAT WE CAN ASSIST PEOPLE IN THEIR SELF-CARE BY MAKING INFORMATION ON EFFECTIVE HEALTH PROMOTION TECHNIQUES MORE WIDELY AVAILABLE THAN THEY NOW ARE. YOUR MEMBERSHIP IS IN A

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PARTICULARLY GOOD POSITION TO EDUCATE PEOPLE ON HOW TO MAINTAIN GOOD HEALTH.

THE IMPORTANCE OF PERSONAL INITIATIVE IN HOW HEALTHY OUR CITIZENS ARE IS ESPECIALLY CLEAR WHEN WE LOOK AT OLDER PERSONS. IN THE PAST FEW YEARS, THE MAJORITY OF ELDERLY PERSONS HAVE REPORTED THAT THEY BELIEVE THEIR HEALTH STATUS HAS NOT CHANGED. IN FACT, MANY OLDER PERSONS FEEL THEIR HEALTH HAS ACTUALLY IMPROVED IN THE PAST YEAR. THE PRIMARY REASONS GIVEN BY ELDERLY PERSONS FOR THIS ARE CHANGES IN LIFESTYLE AND IMPROVED MENTAL ATTITUDE. THE AVAILABILITY OF HOME CARE HAS BEEN OF ASSISTANCE IN ESTABLISHING THIS ATTITUDE.

HOME HEALTH CARE HAS COME TO BE A MAJOR NATIONAL HEALTH POLICY ISSUE IN THE PAST FEW YEARS, AS YOU ARE WELL AWARE. ALTHOUGH FEDERAL PROGRAMS CURRENTLY PROVIDE OR PAY FOR SOME HOME HEALTH SERVICES IN THE COMMUNITY, THERE IS CONSIDERABLE INTEREST IN EXPANDING THE AVAILABILITY AND COVERAGE OF THIS TYPE OF CARE. A NUMBER OF TRENDS APPEAR TO HAVE CONTRIBUTED TO THIS PHENOMENON. I THINK IT WOULD BE HELPFUL TO BRIEFLY DISCUSS SOME OF THESE.

FIRST, THE RAPID GROWTH IN THE SIZE OF THE ELDERLY POPULATION IN THIS COUNTRY HAS INEVITABLY LED TO GRADUAL CHANGES IN THE DEMAND FOR HEALTH CARE. THE PROPORTION OF ELDERLY IN THE POPULATION INCREASED FROM ABOUT 5 PERCENT IN 1920 TO MORE THAN 11 PERCENT IN 1980. THE LARGEST GROWTH AMONG THE ELDERLY DURING

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THIS PERIOD WAS AMONG PEOPLE AGE 75 OR OVER. IF WE LOOK AT DEMOGRAPHIC PROJECTIONS FOR THE NEXT QUARTER CENTURY, WE SEE THE OLDER SEGMENT OF THE GENERAL POPULATION INCREASING FAR MORE DRAMATICALLY. THESE REALITIES INDICATE THE NEED FOR US TO ADJUST THE PRESENT SYSTEM OF HEALTH CARE DELIVERY TO MORE ACCURATELY REFLECT THE CHANGING DEMANDS THAT IT WILL BE EXPECTED TO MEET.

A SECOND TREND WE SHOULD RECOGNIZE AS REINFORCING THE PUSH FOR HOME HEALTH CARE IS A GENERAL DESIRE TO IMPROVE THE PHYSICAL AND MENTAL HEALTH STATUS OF THE ELDERLY. OUR SOCIETY TODAY IS MORE AWARE OF THE SPECIAL AND LEGITIMATE HEALTH NEEDS OF THE AGED POPULATION, AND IS LOOKING SERIOUSLY AT WAYS TO IMPROVE THOSE AREAS WHERE THE CURRENT HEALTH SERVICE DELIVERY SYSTEM IS CLEARLY INADEQUATE. THE SHEER NUMBER OF ELDERLY PEOPLE IN OUR SOCIETY GUARANTEES THAT THIS AWARENESS WILL CONTINUE TO GROW.

A THIRD FORCE THAT HAS HELPED TO POPULARIZE THE CONCEPT OF HOME HEALTH CARE, AND ONE THAT IS PARTICULARLY IMPORTANT TO ME FROM MY VANTAGE POINT IN CONGRESS, IS THE URGENT NEED TO REDUCE HIGH GOVERNMENT EXPENDITURES FOR NURSING HOME AND HOSPITAL CARE. AS CHAIRMAN OF THE COMMITTEE WITH JURISDICTION OVER THE MEDICARE AND MEDICAID PROGRAMS, I AM CONFRONTED DAILY WITH THE THREAT POSED BY THE ALARMING INCREASES IN HEALTH CARE COSTS, BOTH TO THESE PROGRAMS AND TO INDIVIDUALS PURCHASING HEALTH CARE.

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I'D LIKE TO TAKE A MINUTE TO RELATE TO YOU SOME FACTS ABOUT WHAT THE GOVERNMENT PAYS FOR HEALTH CARE SERVICES DELIVERY.

HEALTH CARE COSTS

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. GOVERNMENT HAS LONG RECOGNIZED THE MEDICAL COST PROBLEM, 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 DO SO ANYTIME SOON. 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.

THE COSTS OF INPATIENT HOSPITAL CARE ARE THE MAJOR COMPONENT OF THE NATION'S HEALTH SPENDING, AND ACCOUNTED FOR APPROXIMATELY 72 PERCENT OF MEDICARE EXPENDITURES IN 1980. SINCE THE INCEPTION OF THE MEDICARE PROGRAM IN 1965, ANNUAL SPENDING BY

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THE GOVERNMENT FOR HOSPITAL SERVICES HAS INCREASED OVER EIGHTFOLD. CLEARLY, MEDICARE MUST BEAR A LARGE PART OF THE RESPONSIBILITY FOR THIS REMARKABLE INCREASE. THESE FACTS ALSO POINT TO THE URGENCY FOR RESTRUCTURING THE MEDICARE PROGRAM TO PROMOTE EFFICIENCY ON THE PART OF INSTITUTIONAL PROVIDERS.

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.

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 THAN THAT IN MEDICARE, 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.

WHILE SOME OF THE CHANGES MAY INVOLVE A SHIFTING OF PRIORITIES WITH RESPECT TO BENEFITS AND ELIGIBLE POPULATIONS,

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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 REESTABLISH 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.

FINALLY, I THINK WE CAN BE SURE OF AT LEAST ONE THING: CHANGES IN MEDICARE AND MEDICAID WILL CONTINUE BECAUSE OF OUR CONCERN OVER INCREASING COSTS.

HOME HEALTH BENEFITS UNDER MEDICARE AND MEDICAID

AS WE HAVE SAID, IN-HOME SERVICES TO THE ELDERLY ARE COMING INTO THE NATIONAL LIMELIGHT, DUE IN LARGE PART TO THE INCREASED DEMAND FOR SUCH SERVICES BY THE AGED. THE NUMBER OF HOME HEALTH PROVIDERS HAS INCREASED RAPIDLY IN RECENT YEARS TO MEET THIS GROWING DEMAND, AND TO COMPETE WITH THE TRADITIONAL TYPES OF HOME HEALTH PROVIDERS--VISITING NURSE ASSOCIATIONS (VNA'S) AND PUBLIC HEALTH DEPARTMENTS. THIS COMPETITION HAS LED TO AN INCREASE IN CLIENT ACCESS TO HOME HEALTH SERVICES, IN RURAL AND URBAN AREAS, FOR WHICH YOU ARE TO BE HIGHLY COMMENDED.

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CHANGES TO THE MEDICARE PROGRAM OVER THE YEARS HAVE ALSO PLAYED A SIGNIFICANT ROLE IN THE INCREASED AVAILABILITY OF HOME HEALTH CARE FOR THE AGED. MEDICARE CURRENTLY PAYS FOR MORE HOME HEALTH SERVICES THAN ANY OTHER FEDERAL PROGRAMS. IT HAS BEEN ESTIMATED THAT $1.146 BILLION WILL BE SPENT IN FISCAL YEAR 1982 ON MEDICARE BENEFIT PAYMENTS FOR HOME HEALTH SERVICES. THIS REPRESENTS A DRAMATIC INCREASE OVER THE $287 MILLION SPENT IN FISCAL YEAR 1976. A DOUBLING IN THE PAST 10 YEARS OF THE NUMBER OF HOME HEALTH VISITS REIMBURSED BY MEDICARE HAS UNDOUBTEDLY CONTRIBUTED TO THIS GROWTH.

HOME HEALTH HAS BEEN A COVERED BENEFIT UNDER BOTH PART A AND PART B OF MEDICARE FROM THE BEGINNING OF THE PROGRAM IN 1966. THE HOME HEALTH BENEFIT IS THE ONLY MEDICARE BENEFIT WHICH REMAINS FREE OF ANY DEDUCTIBLE OR COINSURANCE CHARGE. SERVICES PROVIDED ON A VISITING BASIS TO A PERSON IN HIS OR HER RESIDENCE INCLUDE PART-TIME NURSING CARE; PHYSICAL, OPCCUPATIONAL, OR SPEECH THERAPY; AND HOMEMAKER HOME HEALTH AIDE SERVICES.

I SHOULD EMPHASIZE THAT MEDICARE HOME HEATLH SERVICES ARE GEARED TO HOMEBOUND INDIVIDUALS IN AN ACUTE MEDICAL SITUATION CALLING FOR TEMPORARY CARE. THEY ARE NOT DESIGNED TO SERVE AS A CONTINUING SOURCE OF LONG TERM CARE FOR THE NONINSTITUTIONALIZED ELDERLY.

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IT WASN'T UNTIL THE MID-1970'S THAT THE HOME HEALTH BENEFIT BEGAN TO SHOW SIGNIFICANT GROWTH. THE TRIGGERING DEVICE SEEMED TO BE THE MEDICARE AMENDMENTS OF 1972, WHICH SIMPLIFIED VARIOUS ADMINISTRATIVE MATTERS CONCERNING THE PAYMENT OF HOME HEALTH SERVICES, ELIMINATED COINSURANCE PROVISIONS, AND EXTENDED MEDICARE COVERAGE TO DISABLED PERSONS AND TO PERSONS WITH END STAGE RENAL DISEASE.

THE GROWTH OF HOME HEALTH CARE UNDER MEDICARE IS APPARENT IN MANY AREAS. MEDICARE CASH OUTLAYS FOR HOME HEALTH, ACCORDING TO THE HEALTH CARE FINANCING ADMINISTRATION, INCREASED FROM $70 MILLION IN FY 1972 TO AN ESTIMATED $895 MILLION IN FY 1981; THE NUMBER OF MEDICARE SUPPORTED HOME HEALTH VISITS ROSE FROM 5.2 MILLION IN 1972 TO 19.2 MILLION IN 1979; AND THE NUMBER OF MEDICARE CERTIFIED HOME HEALTH PROVIDERS JUMPED FROM ABOUT 2,100 IN 1972 TO ABOUT 3,100 IN 1981. BY THE END OF 1979, ABOUT 975,000 MEDICARE BENEFICIARIES WERE RECEIVING HOME HEALTH BENEFITS.

EVEN NOW, WHEN WE ARE BEING TOLD THAT THE MEDICARE PROGRAM COULD BE FINANCIALLY INSOLVENT AS EARLY AS 1987, IT APPEARS THAT THE HOME HEALTH COMPONENT OF MEDICARE IS IN A PERIOD OF ACCELERATED GROWTH. ONE BASIS FOR THIS EXPECTATION IS THE 1980 CONGRESSIONAL AMENDMENTS TO THE MEDICARE LAW. IN THESE AMENDMENTS, WHICH TOOK EFFECT ON JULY 1, 1981, CONGRESS ELIMINATED: (1) THE 100-VISIT LIMITATION UNDER PART A OF

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MEDICARE, (2) THE THREE-DAY PRIOR HOSPITALIZATION REQUIREMENT UNDER PART A, AND (3) THE $60 DEDUCTIBLE FOR HOME HEALTH BENEFITS UNDER PART B. IN ADDITION, AND PERHAPS MOST SIGNIFICANTLY, IT ALLOWED PROPRIETARY HOME HEALTH AGENCIES TO BE MEDICARE CERTIFIED IN STATES WITHOUT AUTHORIZING LICENSURE LAWS.

THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA) CREATED A NEW TYPE OF HOME HEALTH BENEFIT AVAILABLE TO MEDICARE RECIPIENTS--HOSPICE CARE. BASED ON LEGISLATION I INTRODUCED IN LATE 1981, THE PROVISION IN TEFRA PROVIDES HOSPICE COVERAGE FOR PERSONS JUDGED TO BE IN THE LAST SIX MONTHS OF LIFE. A MEDICARE BENEFICIARY CAN ELECT TO RECEIVE HOSPICE CARE INSTEAD OF THE TRADITIONAL MEDICARE BENEFITS AVAILABLE. SOME OF THE TYPES OF SERVICES COVERED UNDER THE BENEFIT INCLUDE NURSING CARE, HOMEMAKER HOME HEALTH AIDE SERVICES, SHORT-TERM INPATIENT CARE, OUTPATIENT DRUGS FOR PAIN RELIEF, BEREAVEMENT COUNSELING, AND RESPITE CARE FOR THE PATIENT'S FAMILY.

THE HOSPICE BENEFIT UNDER MEDICARE WILL BE EFFECTIVWE NOVEMBER 1, 1983. THE DELAY WAS INTENDED TO ALLOW CONGRESS AND THE ADMINISTRATION AN OPPORTUNITY TO LOOK AT A NUMBER OF STUDIES SCHEDULED TO BE COMPLETED THIS YEAR. I UNDERSTAND THE DRAFT REGULATIONS ON THE HOSPICE BENEFIT ARE EXPECTED TO BE PUBLISHED VERY SHORTLY.

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As you know, hospice care has a very rich history of delivering palliative care to terminally ill patients, in both the U.S. and Europe, and represents a less costly alternative to institutional care. I look forward to the implementation of the Medicare hospice benefit, and hope the program will realize some savings as a result.

The Medicaid program also covers home health services for the poor. The number of Medicaid recipients receiving home health services more than tripled from 1973 to 1979. Medicaid expenditures for home care rose from $25.4 million to $263.6 million over the same period.

In 1981, the Congress passed legislation which created a program of State waivers under the Medicaid program to provide home- and community-based services to a broader range of individuals. The purpose of the waivers was to encourage States to begin to experiment with different forms of health service delivery in an effort to meet the needs of more individuals and reduce the use of institutional services. I believe the States have a great deal to teach us about alternative delivery systems, and am pleased to see the response by the States to these new waivers. Clearly, we continue to be interested in assuring that Medicaid recipients, along with Medicare beneficiaries, receive the highest level of care in the most appropriate setting.

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Push For Expansion

The push to expand the coverage of home health services currently available in Federal health programs is, indeed, becoming a powerful force. The stated goals of home health proponents--wider availability of health care to the noninstitutionalized elderly and the prevention of institutionalization where less costly (and more convenient) care in the home would be appropriate--cannot be disputed. And, yet, I am concerned that in expanding home health benefits, we will be opening the door wider than the government can realistically afford to open it.

I don't think there is any doubt that the availability of home health services to the poor and elderly has helped reduce the length of hospital stays, and thereby has achieved cost savings to Medicare and Medicaid. Indeed, many of the people seen by doctors today might well have been in a hospital or nursing home were it not for the existence and accessibility of home health services. Families with an older relative living in their home may be able to keep that relative at home with the help of home health services, where otherwise they might not be able to cope with the relative at home. I believe these benefits must not be underestimated as we consider the relative costs and benefits of expanding home health services.

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I HAVE TO ASK MYSELF A NUMBER OF SERIOUS QUESTIONS WHEN LOOKING AT THIS ISSUE. FOR INSTANCE, HOW MANY MORE PEOPLE WILL UTILIZE HOME CARE IF WE EXPAND CURRENT ELIGIBILITY LIMITS? AND WHERE WILL THE MONEY COME FROM TO PAY FOR THE HOME HEALTH SERVICES DELIVERED TO THIS WIDER ELIGIBLE POPULATION? AND PROBABLY MOST PIVOTAL TO CURRENT DISCUSSION, WILL THE SAVINGS FROM LESS FREQUENT AND SHORTER INSTITUTIONALIZATION REALLY OFFSET THE HIGHER COST OF EXPANDED SERVICES?

AS YOU AND I BOTH KNOW, THESE ARE DIFFICULT QUESTIONS TO ANSWER. A NUMBER OF STUDIES DESIGNED TO INVESTIGATE THESE ISSUES HAVE TURNED UP INCONCLUSIVE RESULTS. THIS DOESN'T MEAN WE CAN SIMPLY IGNORE THESE QUESTIONS, JUST BECAUSE WE HAVEN'T GOT COMPLETE ANSWERS YET. IT MEANS PEOLE LIKE YOU NEED TO MAKE SURE THAT THE MOST ACCURATE AND COMPREHENSIVE INFORMATION POSSIBLE IS AVAILABLE TO THOSE STUDYING THE MATTER. IT ALSO MEANS YOU MUST BE ABLE TO OFFER CONSTANT PROOF OF THE EFFICIENCY AND COST EFFECTIVENESS OF HOME HEALTH SERVICES AS A WAY OF PROVIDING CARE TO THE ELDERLY AND POOR. AND, FINALLY, IT MEANS YOU HAVE TO HELP FIND THE ANSWERS TO THESE QUESTIONS IN ORDER FOR US TO MAKE INFORMED AND REALISTIC POLICY DECISIONS.

OUTLOOK IN CONGRESS AND THE WHITE HOUSE

LEGISLATION TO EXPAND THE AVAILABILITY OF HOME HEALTH SERVICES IS WELL UNDERWAY IN THE 98TH CONGRESS. THE SUPPORTERS

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OF SIMILAR LEGISLATION OFFERED IN THE LAST CONGRESS ARE LIKELY TO BE ACTIVE IN THIS AREA AGAIN.

ANY LEGISLATION WHICH WOULD ALTER THE MEDICARE PROGRAM IN TERMS OF THE HOME HEALTH BENEFIT WILL HAVE TO BE REFERRED TO THE FINANCE COMMITTEE. AS CHAIRMAN, I INTEND TO EXAMINE CAREFULLY HOME HEALTH CARE LEGISLATION, KEEPING IN MIND THE QUESTIONS I HAVE ALREADY POSED. I SINCERELY HOPE WE CAN FIGURE OUT SOME MECHANISM TO MEET THE NEEDS OF THOSE ELDERLY AND POOR PEOPLE WHOSE HEALTH CARE NEEDS DO NOT WARRANT INSTITUTIONALIZATION, BUT WHO ARE UNABLE TO PAY FOR CARE IN THE HOME.

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