OUTLINE OF REMARKS

COUNCIL OF AMERICAN SPECIALTY SOCIETIES

October 3, 1983

L'Enfant Plaza Hotel--Washington, D.C.

I. The Need for a Budget Summit

A. Many of you may know that I called the First Concurrent Budget Resolution a dead cat. Very little has changed in recent weeks. In my view, the budget process will not be resurrected and the economic recovery secured until our leaders, from the President and the Congress to our State and local officials and business and civic leaders, pull together in order to safeguard the domestic economy. We cannot allow progress toward recovery to lull us into acquiescence.

B. That is why I have called for a budget summit and one where the President plays a key role. Just as Congress must put spending in order, the President must make clear his priorities on the budget. We need his leadership and his approval, because we know he can get the job done. He has done it before: all he needs is a clear sense of purpose.

C. The summit concept will have to begin with the President and with the Congress, but it should not stop there. All decision-makers in our economy, including business and labor, have a vital stake in what happens. We cannot please everybody, but only if we agree on the absolute priority of cutting the deficit in a way that advances our shared economic goals will we have a fighting chance to succeed. We cannot tax our way out of recession, and we cannot devastate the social and benefit programs that so many Americans depend on. But we can make adjustments on both sides of the ledger that boost the odds in our favor.

II. The Economy

A. Prognosis. We have to realistically assess the state of the economy and the prospects for the next few years. Recovery is well under way, and the groundwork has been laid for stable and lasting growth without renewed inflation. It is absolutely crucial that we proceed with care at this point, and not throw away the gains already made.

No one should doubt that we are making progress. The GNP for the second quarter of 1983 shows growth at a 9.2 percent rate: The greatest quarterly expansion since 1975. The index of leading economic indicators has jumped 11 months in a row. Industrial output rose 2.1 percent in April; the highest monthly rise in 8 years, 1.2 percent in May, 1.0 percent in June, and 1.8 percent in July. Economists agree we are in a broad based recovery.

1. Inflation was cut to 3.9 percent in 1982, from 12.4 percent in 1980. This is the lowest inflation rate since 1972. Consumer prices rose just 2.4 percent in the 12-month period ending July 1983, the lowest since 1966. Inflation in 1983 so far is running at annual rate of 3.2 percent. Even with an upward "blip" in producer prices, the inflation picture remains very good. Labor productivity rose 5.7 percent in the second quarter, contributing to further progress on inflation.

2. Interest rates are down. Although the prime rate is at 11 percent, it is still way down from the 21 percent that prevailed when President Reagan took office. Home mortgage rates are down since last year. Long-term rates for business loans are off about 3 points from a year ago.

3. Lower taxes with major improvements in tax equity will help buoy the recovery, both on the consumer side and on the investment side. The combined effect of the 1981 and 1982 tax bills has been to lower individual taxes over 3 years by $344 billion, as well as improve compliance and tax fairness. Lower individual rates boost personal income and restore incentive, while favorable capital cost recovery rules should spur investment.

4. Housing starts are up. At an annual rate of about 1.7 million in June and July, down slightly from May, new housing starts are the highest in 3 years.

o Sales of new one-family houses in June were at an annual rate of 638,000. While this is slightly below the May rate, it is up 73 percent from a year ago. Following a surge in the latter half of 1982, sales activity has moderated in the last 6 months.

o During the first 6 months of 1983, 326,000 houses were sold, up 68 percent from same period in 1982. About 56,000 new houses were sold in June.

B. Unemployment. The July unemployment rate fell from 10.0 percent to 9.5 percent, the largest monthly decline since December 1959. Total civilian employment now stands at 101.6 million, the highest level in our history. These figures indicate that the recovery is anything but anemic. According to Janet Norwood, Commissioner of the Bureau of Labor Statistics, the growth in employment at this point in the recovery is stronger than in any of the previous six recoveries. The number of unemployed has declined by 1.3 million since December 1982.

o High unemployment has to come down and stay down without inflationary stimulus--that is what we have failed to do in the past. Clearly there is a bipartisan consensus for more jobs. But resuming the inflationary policies of the past will not create lasting jobs, just an illusion of prosperity that leaves us worse off the next time we try to get "off the wagon."

o That means the most important thing we must do is judge carefully the degree of stimulus the economy can and should take, consistent with a firm anti-inflation policy. The Federal Reserve will play a key role, and has already shown a willingness to adjust its short-term goals based on its assessment of the economy. We will not allow the recession to continue, but we will not reinflate the economy, either.

In addition, constructive steps have been taken:

- A new Federal supplemental unemployment compensation program was passed with the 1982 tax bill, providing additional unemployment benefits to almost 3 million workers. This program will extend through September 30.

- The new Job Training Partnership Act emphasizes training for permanent employment rather than make-work jobs.

- The targeted jobs tax credit, which was extended for 2 years by the 1982 tax bill, gives employers an incentive to hire the disadvantaged--about 600,000 workers are certified under the program.

- The administration's enterprise zone legislation, which was approved by the Senate, could provide us with an experiment in private-sector job creation in depressed areas, through a combination of Federal tax incentives and State and local efforts to target an area for development with regulatory and tax relief, neighborhood participation, and capital and other improvements. House hearings have been promised.

C. The Deficit and Interest Rates.

1. All our economic difficulties are, of course, related--high interest rates and slow growth boost the deficit, and higher deficits create greater uncertainty in the business community as to our future course; will there be more inflation, or less credit available for business expansion?

2. Because of this, it makes sense first of all to chart a path that is most likely to bring stable growth without inflation. Higher growth boosts revenues and cuts unemployment costs, thereby reducing the deficit as well: already, upward revisions of growth estimates are being made in light of our economic progress and indications of further improvements.

3. Continued efforts to restrain the deficit by controlling Federal spending will give the Federal Reserve a bit more room to accommodate the potential for real growth that exists in the economy without inflationary pump-priming. But restraint in both fiscal and monetary policy is crucial if we want to maintain long-term confidence in the economic program. The reappointment of Chairman Volcker at the Federal Reserve is a good move towards maintaining public confidence.

III. Medicare Costs

- Recent estimates show the medicare hospital trust fund as being depleted as early as 1990. 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 10.5 percent from now until 1995, while the basis for trust fund income is expected to grow at an annual rate of only 7.0 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.

- 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. But it's also, more than anything else, a physician problem.

- It is the physician who drives the health care system. He or she orders the tests, admits the patient, performs the surgery, and prescribes the drugs. Perhaps more importantly it is what he or she does not do that significantly contributes to the problem. He or she does not, in the opinion of many, consider what it costs to provide the services he or she prescribes.

- Hospitals have been in this situation with respect to medicare. Cost reimbursement provided hospitals with financial incentives to provide more services, extend lengths of stay, and adopt new technologies, whether cost-effective or not. Those days are over. Prospective payment was adopted as a way of changing incentives, rewarding efficiency, and curbing cost growth. But hospital prospective payment is not the entire 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.

- 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 acutuarial balance, either outlays will have to be reduced by 30 percent or income increased by 43 percent.

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

IV. Value of Cost Sharing

- Cost reductions without beneficiary participation is a grand idea. It leads people into thinking that in our efforts to contain budget deficits they will not be hurt. But that is a mistaken notion. They will be hurt, as the deficit grows and the ability of the trust fund to finance needed health care shrinks. Beneficiaries are concerned. Taxpayers are concerned. And we should be concerned enough to realize that including beneficiaries in our cost reduction proposals is essential.

- Medicare beneficiaries, along with other patients, should be made sensitive to the high cost of care. Price sensitivity makes sense where the beneficiary's decision to seek medical care is his or hers to make and it does not cause needless delay in seeking needed care. Cost sharing can be useful and is appropriate in many instances. But we must use caution.

- We know that free care leads to increased use of medical services. For example, between 1971 and 1980 the average number of home health visits, which require no cost sharing, increased by 352 percent per beneficiary.

- The idea of cost sharing to deter unnecesary utilization and dampen spiralling health care costs is by no means a resolved issue. There are those who strongly favor it, as well as those who oppose it, believing that it defeats the goal of making health care accessible.

- Both groups (those pro and con) agree that cost sharing does deter use, but disagree on the extent to which consumers are capable of making wise choices in that area.

- One other option we have been asked to consider in examining ways to alter cost sharing is increasing the part B premium for those elderly individuals with relatively high incomes. As you recall, we made changes this year with respect to the social security retirement program that would provide for taxing the benefits of wealthier beneficiaries. A change in the Part B premium could be seen as consistent with this move.

V. Physician Payment Reform

- Most certainly, for Part B of the program, cost reductions will focus on physicians. Too long have we avoided reforms in this area on the basis that the consequences of whatever is done will be borne, not by physicians, but by their patients--the medicare beneficiaries. We no longer can hold off the forces calling for mandatory assignment unless we have some other reforms to offer. It is time to act, and physicians are in the spotlight.

- The Finance Committee will soon make available a committee print which provides an overview of physician reimbursement patterns under medicare. Besides providing details of reasonable charge determinations and their effects on both physician and patient, it will review the payment options which are currently under discussion. The Committee will then move forward with hearings sometime this Fall to more fully explore the problem and the solutions.

- I would like to hear from the Council at those hearings. I would like to know what your Societies can do to fashion a solution. I would like to know what can be done about the physician fees.

- The Secretary of the Department of Health and Human Services has been required by the Congress to begin the collection of data necessary to compute by diagnosis related groups (DRGs) the amount a physician charges for services furnished to hospital inpatients.

- In 1985 the Secretary is required to make recommendations to the Congress on the advisability and feasibility of providing for a DRG type payment system for physician services. Last week the Finance Committee adopted a provision which would direct the Office of Technology Assessment to report to the Congress after consultations with physician organizations such as the Council and its member Societies, on ways to modify the existing system for determining Medicare allowances to eliminate inequities that exist between reimburement levels for medical procedures (e.g., surgery) and cognitive services (e.g., physical examinations, complete histories, consultations, etc.). The study would also include specific findings and recommendations on creating a means to adjust allowances to physicians, as costs and risks to physicians which result from new technologies and procedures decreases over time.

- The Committee expects to move ahead on physician payment, utilizing the results of the required studies and the

Committee's hearings. Through these hearings I would also like to know how we can help physicians contend with costs which drive up your fees and therefore program outlays. Malpractice insurance is one thing that comes to mind. I would ask what can we in the Congress do to moderate these costs?

- What can we do to reform the physician reimbursement system in ways that make sense, ensure the availability of quality care, and provide positive rather than negative incentives. Is prospective payment for physician services the only mechanism available with a reasonable chance of success? The answers will not be easy to provide, but provide them we must.

- 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.

- Physicians, I believe, recognize the problem we are facing. I have heard from various physician groups who are willing to spend the time and effort necessary to come up with workable solutions. Certainly the Council can be the organization that provides the leadership and direction in coming up with reforms; reforms that are needed now, not sometime down the road when it is too late.

V. Health Benefits for the Unemployed

- As a result of the unusually high rates of unemployment in the United States today, a growing number of workers and their families have lost their employment-based group health insurance, and their employers' contributions toward the purchase of such coverage.

- The loss of group health insurance for those who have lost their jobs is not a new problem, but the number of workers who have lost their jobs and the duration of such unemployment is unprecedented in modern times, and makes the matter of particular national concern.

- Providing health benefits for the unemployed means replacing coverage workers lost due to their involuntary unemployment. At a time when they can least afford it, laid off workers must turn to nongroup coverage which is more expensive and often less comprehensive than that which was provided through their employment. The simple fact is that they cannot afford such coverage and they certainly can't afford the cost of care when it is

needed--particularly when that care requires a hospital admission.

- Clearly we must take a conservative approach to providing health benefits for unemployed workers. Our approach should target the greatest number of those workers who have lost coverage without creating a complicated outreach and delivery system. We need to achieve the greatest impact with limited funds.

- I do not believe we should simply increase the deficit in order to provide health benefits for the unemployed. Instead, the Congress should adopt offsetting revenues or cost saving so that from a budget standpoint there is no increase in the deficit.

- Much of the solution in the long run will involve the private sector: first, in the provision of open enrollment periods so that those who have lost coverage because someone in their family has lost his or her job can reestablish that coverage under another family member's employer; second, in the limited continuation of employer group coverage for those employees who lost their jobs through no fault of their own. We must work with both employers and the health insurance industry to determine how best to accomplish these reforms.