OUTLINE OF REMARKS

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NATIONAL HEALTH COUNCIL - Equitable Life

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INTRODUCTION

- For years, we've been adjusting this or that element of the medicare program. We've added a regulation here, some monitoring there, but we had never gotten to the heart of the problem--the way we pay for services. The result is that costs have risen unnecessarily for beneficiaries, for hospitals, and for the Federal Government. It was clearly time for a change.

- Prospective payment is the shot in the arm medicare now needs. It's a positive change; good for senior citizens, for doctors, for hospitals, and for taxpayers. And it comes at a time when it is desperately needed.

- Hospitals, of course, are bearing the largest burden of the cuts made in the last two years. This should not be viewed as unusual given that over two-thirds of all medicare dollars are spent on hospital services ($37 billion in 1983).

- As you may recall, the Tax Equity and Fiscal Responsibility Act of 1982 contained a provision directing the Secretary of Health and Human Services to develop, in consultation with the Finance Committee and the Committee on Ways and Means, proposals for the reimbursement of hospitals under medicare on a prospective basis. The Department's report was submitted in late 1982, and hearings were held by the Finance Committee in February. Witnesses present at the hearings representing the hospital industry, provider groups, the insurance industry, consumers and representatives of the business community, raised a great many issues; many of which were clearly addressed in the drafting of the prospective payment legislation.

II. THE NEW PROSPECTIVE PAYMENT SYSTEM

- Hospitals have lacked incentives to control costs because the current cost-based system allows greater payments for ever growing costs. Clearly some change was needed, and that change began with the adoption of incentives for the efficient delivery of hospital services in the form of prospective payment.

- Action on H.R. 1900 was more rapid than many expected or wanted. But when it became clear that the House intended to move ahead, I felt it important that the Senate have an opportunity to discuss the proposal and modify it before conferring with the House on the bill. And in fact, the Senate Finance Committee and the Members of the full Senate did discuss a great many issues and I believe, improved the final bill.

- Let me make it clear from the outset, that there was every desire to construct a bill that would not penalize the hospitals, or put them at risk. Our intention was to really improve the system, making it easier for us and for the hospitals to do their jobs.

- We had been forced in recent years to simply tinker with the 223 limits as a method of reducing program expenditures. This didn't make sense to you or to us. As a result, large numbers of people, including the hospital industry, were supportive of a move away from cost-based reimbursement.

- The provisions contained in H.R. 1900, establishing a prospective system are indeed, not perfect. Any time you attempt to devise a new system of this magnitude, problems occur which you were either unaware of, or unable to resolve at the outset. The medicare prospective payment system is no different. However, I believe ample flexibility has been provided, giving the Secretary of Health and Human Services

the opportunity to adjust the system as we learn more and more about the system's impact.

- The treatment of capital costs will be very difficult to resolve, but resolve it we must. What we do to encourage hospitals to build or invest in new equipment has an enormous impact on health care costs.

- A teaching adjustment was provided in light of doubts about the ability of the DRG case system to account fully for factors, such as severity of illness, which may require the specialized, and often costly, services of teaching institutions. This adjustment is only a proxy to account for those factors which may legitimately increase costs. We are hoping to find some better, more accurate method of addressing both the indirect and direct teaching costs in the future.

Severity of Illness

- Probably one of our greatest concerns is the inability of the new system to differentiate between two different patients within the same DRG.

- While the bill does provide for special treatment for the so-called "outlier" cases, it really doesn't address the problem of internal case mix differences.

- We have asked the Secretary to study the advisability and feasibility of providing for the application of some type of severity modification. We believe this will be particularly important to teaching institutions.

III. MEDICARE COSTS

- In addition to our work on hospital reimbursement, a great deal of additional work is yet to be done to help us address the long term financing problems medicare is beginning to experience.

- 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 healh 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.

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

o Increased beneficiary cost sharing, benefit reforms 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. ACTIONS ON MEDICARE FINANCING CRISIS

o As you all know the Secretary's Advisory Council on Social Security has been meeting for over a year and are expected to report to the Secretary late this year.

o The recommendations compiled by this group will certainly provide us with a basis for discussion although their suggestions will not be the only ones considered.

o There are those who have already begun to press for the establishment of a new Presidential commission to address the medicare crisis. 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 Secuirty rescue plan.

- Discussions should certainly begin immediately on all possible options, including those we are considering in the context of this years budget resolution.

- The Health Subcommittees of both the Energy and Commerce and Ways and Means Committees have met and made a number of suggestions related to program changes. Finance will soon proceed to make its own decisions.

- Clearly the changes agreed to this year will not begin to solve the entire problem- but they are certainly that necessary first step.

- This year and in the years to come as we focus more and more attention on medicare, particular note must certainly be given to both physician reimbursment and beneficiary cost sharing.

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 and 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.

- 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 reimbursement 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.

o 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 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?

o 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. In 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.

o 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.

o 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.

VI. 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 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 unnecessary 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.

OUTLINE

I. Introduction

II. Prospective Payment System (PAGE 2)

Cost based system - no cost control incentives.
HR 1900 moved us ahead - bill improved.
Tinkered in past with limits.
Prospective system not perfect.
Capital costs need resolution.
To account for unknowns
- paid teaching costs
- allowed outlier payments
Need modification for severity (Dept. study due).

III. Medicare Costs (PAGE 5)

Hospital cost growth (10%), trust fund income growth (7%).
Physician cost growth (11% in recent years).
Blame is shared but physician orders services.
Physician does not consider what it costs.
$300 to $400 billion deficit by 1995 unless
- reduce outlays 30%
- increase revenue 43%
Close gap with cost sharing, savings, taxes.

IV. Actions on Financing Crisis (PAGE 7)

Advisory Council will report at year end.
Recommendations will be basis for discussion.
Pressure for Presidential Commission.
Need bipartisan spirit- Congress should act.
House subcommittees have suggested changes.
Finance will act.
Changes will not solve entire problem - First Step.

V. Physician Payment Reform (PAGE 8)

Cost savings will focus on physicians.
Committee print will outline payment options.
Committee hearing to explore problem and solutions.
What can be done to
- Hold down costs (such as malpractice insurance)?
- Maintain quality?
Is prospective payment the only answer?
We need solutions/reforms now.

VI. Beneficiary Cost Sharing (PAGE 11)

Containing deficit without cost sharing is misleading.
Beneficiaries will be hurt. (Deficit-Bankrupt program.)
Patients should be sensitive to costs of care.
Free care means increased utilization.
Unresolved issue - need patient access to care.
- patient must not put off needed care.
Possible option: Increase Part B premiums for those with high incomes.
Consistent with taxing wealthier social security retirees.