OUTLINE OF REMARKS

SENATOR BOB DOLE

AMERICAN ASSOCIATION FOR RESPIRATORY THERAPY

Saturday, October 15, 1983

I. 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.

- Because the current cost-based reimbursement system allows greater payments for ever growing costs, hospitals have lacked incentives to control 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.

- 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.

II. 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.

- 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.

- 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.

III. ACTIONS ON MEDICARE FINANCING CRISIS

- As you may know, the Secretary's Advisory Council on Social Security has been meeting for over a year and is expected to report to the Secretary late this year.

- 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.

- 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 year's 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.

IV. PHYSICIAN PAYMENT REFORM

- Most certainly, for Part B of the program, cost reductions will focus on physicians. For 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.

- 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.

- For the future you should know that it is unlikely that we will consider expanding the fee-for-service payment

mechanism to other than those providers or services currently paid for on that basis. As a matter of fact, we may consider other payment methods to replace fee-for-service where it currently exists.

V. BENEFICIARY 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.

- 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 as to whether consumers may put off needed care. For that reason, we must use caution.

VI. HOME HEALTH CARE

- For several years, respiratory therapists have sought specific changes in the medicare program that would authorize reimbursement for respiratory services as a primary benefit under the home health benefit. Certainly yours is not the only change sought in this area, but is certainly worthy of our consideration.

- The demand for expanded home health care services is stimulated not only by the drive to substitute home care for hospital inpatient care, but also by the aging of the population, a growing patient desire for out-of-hospital treatment, and advances in medical technology. The simplest explanation, however, is that home care generally costs less than hospital care and patients prefer such care over hospitalization for the non-acute stages of most diseases.

- For fiscal year 1983, medicare reimbursement for home health care will total $1.5 billion, up 146 percent from 1979. In five years, the total is expected to rise to $2.6 billion. Such an expansion leads to concerns about ensuring the quality of the care provided and the appropriate utilization of that care. Moreover, there are questions as to whether

home health services simply expand to serve a new population of aged individuals without a corresponding reduction in nursing home and hospital use.

- Until we can assure the solvency of the medicare program, any movement in a direction which is likely to expand coverage of additional services or providers, to a greater extent than there is a substitution of lower cost home care for higher cost institutional use, is unlikely.

- Of course, in looking to the future we must recognize that the implementation of prospective payment for inpatient hospital services will move hospitals to seek greater access to all forms of long-term care including home health care services, as a means of getting patients out of higher cost hospital beds. That movement has already started. Lifemark Corporation, a Houston-based hospital chain is expanding its home care services for just that reason.

- It is likely that as a result of patients being discharged earlier, their needs for skilled post-hospital care may be greater in both the nursing home and home health setting. To meet these needs, we will certainly need to reexamine the structure of these benefits--and respiratory therapy will obviously be an element of those services considered.

- Clearly further alterations in the methods we in the public sector use to pay for care are ahead. Given the passage and

implementation of prospective payment for hospitals, many would now like to see such a system expanded to other providers--including nursing homes, and home health agencies.

o Many, however, feel we should move slowly--so as not to put the entire system under one form of payment that has yet to be tested on a nationwide basis. Complicating all this is the issue of the financing of long-term care.

VII. LONG-TERM CARE

o Besides the obvious concerns about the cost and financing of long-term care there are other factors which will lead to the consideration of restructuring the entire system of long-term care. For one thing, the elderly population in general is increasing rapidly and the population at risk of needing long-term care may be increasing especially fast. Various sources suggest that the long-term care needs of the elderly have intensivied--patients are functionally more impaired and require more intensive care.

o At the present time we do not know what long-term care really is. We do know it is medical care, nursing care, mental health care, and social services care, funded in some instances through medicare or medicaid. We know its purpose is to relieve the effects of illness, to maintain or enhance functional capacities and to maximize personal independence.

But we have not defined long-term care in terms of an overall scheme for matching services to needs through a single program, or by coordinating existing programs.

- Long-term care may well be the major health and social issue of the future, polarizing society over the next 20 to 40 years.

- When the baby-boom generation retires, the financial and resource needs of long-term care may compete fiercely with those of defense, education, energy, and welfare; creating much political controversy.

- The dimensions of the long-term care problem are rooted in the basic demographics of American society. A 65 year old in 1980 could expect to live to age 81, and an 85 year old to age 91.

- The number of Americans 65 and older has grown from about four million in 1900 to 24 million in 1979, and will continue to rise at least until the year 2035. By 2030, there may be 55 million people over 65.

- Depending on fertility projections, there may be anywhere from 2-1/2 to 4 working-age individuals (18 to 64 years old) for each retirement-age elderly individual. The resource-absorbing implications of this long-term care and income maintenance burden are awesome.

- Nursing home, health care, and hospice care--these are but a few of the many elements of providing long-term health care to the needy, the elderly, and the disabled through the medicare and medicaid programs. They are complex aspects in and of themselves and they are interrelated. The more we know about those interrelations and complexities, the better we will be able to consider how they might be restructured to provide better care on a cost effective basis.

- Since long-term care dependency is very much a function of advancing age, the demographic reality just outlined presents the United States with an extraordinary task in terms of both money and providing services over the next 40 years at least. We have, of course, been dealing with this task to some degree, but its real dimensions have only recently been recognized and raise some important policy issues:

  - Will we continue the pattern of institutional development so characteristic of the years since the introduction of medicare and medicaid or will we attempt to develop more community-focused systems?

  - If we decide on a more community-oriented care system, will the community support be available to provide care? Will community-based care serve as a substitute for, or an add-on to, institutionalized care?

- These are but a few of the questions that need answers. This fall the Health Subcommittee will begin a series of hearings to seek out answers to these and other questions about long-term care. Most importantly, how much care should we provide and what portion of it should be financed through the Federal Government?

SUMMARY

- Prospective payment for hospitals does not solve the medicare financing problem. Instead, it is the first piece of a solution.

- To close the gap between medicare outlays and revenues will require some mix of cost sharing, cost reductions, and revenues. Physician payment reform will be examined in depth as part of cost reductions. The Congress must move ahead to adopt the measures necessary to ensure the solvency of the program. Until then, a simple expansion of benefits is unlikely.

- For the future we must also begin to consider the growing long-term care needs of a growing elderly population.

- The Committee will move ahead on both fronts. In doing so, we are interested in the views of respiratory therapists. We seek solutions that will truly work. I hope your organization and your members will be a party to our efforts.

United States Senate
COMMITTEE ON FINANCE
WASHINGTON, D.C. 20510

October 11, 1983

TO: SENATOR DOLE

FROM: SHEILA BURKE AND ED MIHALSKI

RE: KEYNOTE SPEECH - AMERICAN ASSOCIATION FOR RESPIRATORY THERAPY (KANSAS CITY - OCTOBER 15)

The American Association for Respiratory Therapy (AART) is a 25,000 number organization representing respiratory therapy practitioners who provide medicare services in the hospital inpatient setting, in outpatient clinics, and in rehabilitation facilities. The Association's letter of October 6, 1983 provides background information on the conference participants, program and legislative concerns.

Legislative Concerns

Coverage of respiratory services as a home health care benefit is sought by the Association. Your talking points address the issue. Although cost savings are claimed for such expanded coverage it is not clear that home respiratory care will only result in direct substitution for hospital-based care. Expanded home care may also cause the new benefit to be provided to many non-hospitalized beneficiaries. Until the medicare financing crisis is addressed it is unlikely we would expand coverage.

The Association opposes an Administration-proposed change in medicare regulations that would prohibit respiratory therapists from administering drugs. There is every indication that the final regulations, when issued by the Secretary, will not include such a prohibition where state laws allow respiratory therapists to administer drugs.

Boyd Davies

Mr. Boyd Davies of Pratt, Kansas has written to you about captive referrals -- instances where a hospital, nursing home, or home health agency refers its patients to a durable medical equipment(DME) supplier which is an integral part of or is affiliated with the referring entity. Mr. Davies objects to such referrals as being anti-competitive. Also, he alleges that the referring entities steer patients to DME suppliers which then pay the referring parties a fee, i.e., kickback. He has discussed the issue with us. As a solution he proposes to bar hospitals, nursing homes, and home health agencies from dealing in DME. Mr. Davies is expected to be at the AART convention and may buttonhole you on this issue.

You should know that current law already makes bribes and kickbacks under medicare a felony offense subject to a $25,000 fine or 5 years imprisonment or both. You may want to suggest that Mr. Davies provide any evidence of wrongdoing to the Inspector General, meanwhile, we will continue to keep the issue in mind.