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Pfizer Company Employees

Max S. Baucus

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REMARKS OF
THE HONORABLE MAX BAUCUS
BEFORE THE
PFIZER COMPANY EMPLOYEES
NEW YORK, NEW YORK
APRIL 5, 1983

INTRODUCTION

Thank you very much for inviting me to be with you today.

As employees of a very fine drug company, I thought you would be interested in the latest developments in health legislation. Just the week before last, the Senate took action on the Social Security Reform package. Attached to that package was a plan to change the way Medicare pays hospitals for the care they provide.

In addition, the House and Senate Budget Committees are putting the final touches on next year's budget targets. These resolutions will set forth savings for spending programs -- like Medicare and Medicaid -- and they will put in place revenue goals for tax programs.

The budget resolutions will lay the foundation for the debate on specific health proposals -- like catastrophic insurance, beneficiary cost-sharing, and the employer tax cap -- that will be considered later this year.

Further, some of us are beginning to give serious attention to the problems facing the Hospital Insurance Trust Fund, that's the fund that pays Medicare hospital benefits. The solvency of
this Trust Fund has concerned me for some time. But only in the
last month or two has there been any media attention given to it.

I would like to spend some time today sharing my views with
you on the problems facing Medicare in the next few years.

HEALTH COSTS

As you well know, today we are spending more than ever for
health care, but getting less for our money.

Health expenditures--both public and private--are continuing
to increase even though the economy is showing very little
inflation.

National health expenditures--the amount we Americans spend
on health--rose last year to $287 billion. That's about 10
percent of the Gross National Product--up from 6 percent of the
GNP in 1965.

Spending for hospital care is the largest component of these
outlays. So, while the consumer price index tumbled from almost
13 percent to 5 percent in the last twelve months, we find that
progress against inflation has stopped at the hospital door.

In 1982, hospital costs went up three times the national
inflation rate. Federal outlays for Medicare rose 21.5 percent
last year. And the cost of private health insurance rose 16
percent in 1982--the biggest increase ever.

Rising health costs are a national problem. Federal, state,
and local governments--who pay 42 percent of the health care
BILL -- ARE WRACKING UP RECORD BUDGET DEFICITS TO MEET THE SOARING COSTS OF MEDICARE AND MEDICAID.

AND HOW DO INCREASED HEALTH EXPENDITURES AFFECT THE PRIVATE SECTOR? WORKERS DRAW LOWER WAGES BECAUSE EMPLOYERS MUST PAY HIGHER HEALTH INSURANCE PREMIUMS.

AND PATIENTS PAY HIGHER PRICES BECAUSE COMPANIES HAVE TO PASS ON MUCH OF THE HIGHER HEALTH INSURANCE PREMIUM COSTS.

IN SOME CASES, THESE COSTS HAVE CONTRIBUTED TO AMERICAN INDUSTRY'S LOSS OF COMPETITIVE POSITION. U.S. STEEL, FOR EXAMPLE, ESTIMATES THAT THE COST OF HEALTH BENEFITS ADD AN EXTRA $20 TO THE PRICE OF EACH TON OF STEEL. AND AMERICAN AUTO COMPANIES FIGURE THE COST OF EMPLOYEE HEALTH BENEFITS TO BE AS MUCH AS $400 ON EACH CAR PRODUCED. THAT'S MORE THAN ONE-QUARTER OF THE REPORTED $1500 COST ADVANTAGE THAT JAPANESE CARS HAVE OVER OURS.

ADMINISTRATION BUDGET PROPOSALS

FOR THE PAST THREE YEARS, THE REAGAN ADMINISTRATION HAS CITED FIGURES SIMILAR TO THE ONES I JUST DISCUSSED. THEIR ANSWER TO RISING COST OF HEALTH CARE, HAS PROPOSED IS CUTS IN MEDICARE BENEFITS.

THE ADMINISTRATION HAS DEVELOPED SOME PROPOSALS THAT APPEAR TO BE TARGETED AT HEALTH CARE PROVIDERS--DOCTORS AND HOSPITALS BUT CLOSE EXAMINATION SHOWS THAT THESE PROPOSALS RESULT IN NOTHING MORE THAN COST-SHIFTING TO HEALTH CARE CONSUMERS.
In 1981, about 80 percent of the changes made in Medicare in that year's Reconciliation Act meant more costs for America's elderly. In 1982, Congress rejected an Administration budget chock full of benefit cuts. Instead, we drafted a hospital cost containment plan. And this year--to no one's surprise--the Administration has proposed the benefit cuts that we rejected last year, as well as a few new ones.

I and others -- including a number of moderate Republicans -- are concerned about this. We fear that this Administration's health experts work on Medicare like they'd peel an onion. Without being too dramatic, it's as if they strip away layer after layer, year after year--until all you're left with is the tears.

Let's look at the two big Medicare cost-savers proposed by the Administration this year: the restructuring of Part A hospital insurance. The Administration is proposing to provide catastrophic health insurance in exchange for greater beneficiary cost-sharing.

Of course, the elderly, on fixed incomes, are rightfully afraid of being bankrupted by high-cost hospital care. We all are.

But the "trade" the Administration is proposing--copayments on days in the hospital, in exchange for catastrophic coverage--is not a fair deal at all.

The cost to the government to provide the catastrophic coverage the Administration wants is minimal. The cost to the
ELDERLY, WHO WOULD HAVE TO PAY MORE OUT-OF-POCKET FOR HOSPITAL CARE WOULD BE GREAT.

Only one-half of one percent of hospitalized Medicare beneficiaries would be helped. Meanwhile, the other 99 1/2 percent of hospitalized beneficiaries would pay $2.2 billion more than under current law.

This doesn't sound like fairness to me. And it won't answer the real problem with Medicare Hospital Insurance.

The idea seems to be that Medicare patients should pay more in hopes that they will use hospitals less.

But the elderly already contribute more than their fair share of cost-sharing. They already pay a great deal through existing deductibles, and premiums, and coinsurance. In fact, studies I have seen show that Medicare covers only about 40 percent of the health expenses of elderly Americans. The question is how much cost-sharing is enough?

But, Federal programs designed to hold down hospital utilization and to promote high-quality care are opposed by this Administration as undue interference with the practice of medicine.

Why should government be prevented from taking every step it can to buy only the best quality care for the clients it serves? Why should government be prevented from making sure that it pays only for health care that is medically necessary?

Three quarters of the savings attributable to the proposals
put forward by the Administration this year will come from the pockets of America's senior citizens. I believe this would break the commitment that was made by Congress in 1965 to guarantee the elderly access to high quality Medicare care.

MEDICARE TRUST FUND

Finally, the cuts in benefits proposed by the Administration do not address the real problem with Medicare—the solvency of the Part A Hospital Insurance Trust Fund. This Trust Fund is financed by payroll contributions paid by employers, employees, and the self-employed.

The most recent projections made by the Congressional Budget Office indicate that we face serious financing problems for Medicare later in this decade. Continued solvency of Medicare's Hospital Insurance Trust Fund will require very substantial increases in revenues or cuts in Medicare outlays—that is cuts in benefits or reduced payments to health providers or increased revenues—that are much larger than any proposals currently under discussion in Washington.

Let me give you some numbers.

Actuaries project that balances in the Medicare Hospital Insurance Trust Fund will be exhausted sometime during 1987. 1987! That's four years from now!

Medicare's basic financial problem arose because hospital costs were growing much faster than the earnings taxed to generate revenue for the Trust Fund.
Hospital costs attributable to Medicare beneficiaries are projected to increase over the 1982-1985 period at an average annual rate of 13.2 percent. Covered earnings which provide revenue for the Trust Fund are projected to grow by only 6.8 percent.

The CBO projects a Trust Fund balance of $1.3 billion at the end of 1986. With no change in existing law, the Trust Fund would show steadily growing deficits—$7.6 billion in 1987 and $70.2 billion in 1990—rising to $221.5 billion in 1993 and $402.9 billion in 1995.

These are sobering figures. And the possible solutions—ranging from higher payroll taxes, to higher charges for Medicare services, to hospital cost controls—would have to be much more stringent than anything proposed to date if they are to keep Medicare solvent.

There is no question that Medicare will have to be restructured in order to make it solvent. But three years of Administration budget proposals have ignored the looming crisis in Medicare.

The budget process is no way to develop the options that would set Medicare on a sound financial basis. We need a national commission—just like the Social Security Commission—to draft a long-range plan for Medicare. And then to undertake the task of building the political support needed to get it passed.

Last month, Senate Democrats formed a Task Force to look at
this issue. As chairman of this Task Force, I intend to develop a "road map" for making sure Medicare is financially sound in the future.

I am sure that some benefits will have to be reordered--and that rising hospital costs and physicians' fees will also have to be curbed--if Medicare is not to go broke.

I think that we can no longer afford to delay action on this matter. You and I both know that it took a political firestorm to prod the Administration to establish a bi-partisan balanced approach to solving Social Security's long-term problems. I'm suggesting to you today that we need a similar bi-partisan balanced approach to manage the challenges facing Medicare.

We must face the Medicare funding problem head on, and begin to forge a realistic solution. We must work together -- Democrats and Republicans, Congress and the Administration.

We must remember that if we succeed, when we succeed, the health of American will be the ultimate winner.