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American Hospital Association (1)

Max S. Baucus

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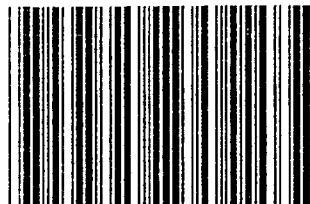
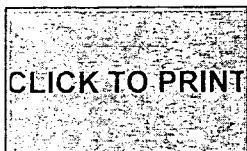
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BAUCUS

STATEMENT OF SENATOR MAX BAUCUS
AMERICAN HOSPITAL ASSOCIATION

HOUSTON, TEXAS

AUGUST 1, 1983

INTRODUCTION

THANK YOU VERY MUCH FOR INVITING ME TO BE WITH YOU TODAY. I'M PARTICULARLY INTERESTED IN THE SPECIAL PROBLEMS FACING SMALL RURAL HOSPITALS, AND I'M PLEASED TO BE GIVEN THE OPPORTUNITY OF DISCUSSING THESE ISSUES WITH YOU TODAY.

ALL TOO OFTEN, OFFICIAL WASHINGTON SEEMS TO GOVERN IN THE CONVICTION THAT "BIGGER IS BETTER", AT LEAST MORE IMPORTANT POLITICALLY.

AS A RESULT, FEDERAL LAWS AND RULES FREQUENTLY DISCRIMINATE AGAINST SMALLER COMMUNITIES. NOWHERE IS THIS MORE EVIDENT THAN IN FEDERAL REGULATIONS GOVERNING HOSPITALS.

THIS WAS MADE PAINFULLY CLEAR TO ME WHEN I CAME TO WASHINGTON AS A NEWLY-ELECTED CONGRESSMAN. YOU NO DOUBT REMEMBER THE NATIONAL HEALTH PLANNING GUIDELINES ESTABLISHED IN THE 70'S BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

THESE GUIDELINES WERE TAILORED TO THE SIZE, THE FUNCTIONS, AND THE NEEDS OF METROPOLITAN HOSPITALS. THEY WOULD HAVE SET UNFAIR STANDARDS FOR HOSPITALS IN SMALL TOWNS. MANY WOULD

HAVE BEEN FORCED TO CLOSE.

THESE GUIDELINES WERE NOT FAIR TO RURAL AREAS. I'M SURE JOE CALIFANO, WHO RAN THE DEPARTMENT AT THAT TIME, STILL REMEMBERS ME DELIVERING A PICK-UP TRUCK FULL OF ANGRY LETTERS FROM MONTANANS TO HIS OFFICE. ENOUGH OF YOU BANDED TOGETHER TO SEE TO IT THAT THE MOST INEQUITABLE SECTIONS OF THESE GUIDELINES WERE REVOKED.

BUT I LEARNED AN INVALUABLE LESSON FROM THAT EXPERIENCE. LIKE IT OR NOT, MOST POLICYMAKERS IN WASHINGTON HAVE A HARD TIME UNDERSTANDING THAT THE SOLUTIONS TO HEALTH PROBLEMS IN MANHATTAN, NEW YORK, ARE NOT THE SAME AS THEY ARE IN MANHATTAN, MONTANA.

MAKING SURE FEDERAL HEALTH PROGRAMS REFLECT THAT FACT HAS BEEN ONE OF MY TOP PRIORITIES. IN THE PAST COUPLE OF YEARS, ^{I HAVE} MOST ~~BROUGHT THIS SPECIAL SENSITIVITY TO CONGRESS CONSIDERATION OF~~ ~~OF MY TIME HAS BEEN SPENT ON~~ MEDICARE'S SECTION 223 COST LIMITS, AND ~~JUST THIS YEAR~~ PROSPECTIVE REIMBURSEMENT.

I WOULD LIKE TO DISCUSS THESE MEDICARE POLICIES WITH YOU, BUT FIRST I WANT TO STEP BACK AND LOOK AT THE HEALTH SYSTEM AS A WHOLE.

HEALTH COSTS

AS YOU WELL KNOW, TODAY WE ARE SPENDING MORE THAN EVER FOR HEALTH CARE, BUT GETTING LESS FOR OUR MONEY.

HEALTH EXPENDITURES -- 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 LAST YEAR, WE FIND THAT PROGRESS AGAINST INFLATION 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.

RIISING 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.

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 ITS 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.

IN ADDITION, I READ RECENTLY THAT THE MAJOR SUPPLIER FOR THE CHRYSLER CORPORATION WAS NOT STEEL -- IT WAS BLUE CROSS AND BLUE SHIELD!

CONGRESSIONAL ACTION

MY COLLEAGUES IN CONGRESS -- REPUBLICANS AND DEMOCRATS -- READ THESE STATISTICS, AND THEY ARE DEMANDING CHANGE.

THEY WANT TO SEE RESULTS.

THAT'S WHY THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT (TEFRA) OF 1982 -- WHICH EXTENDED AND PLACED A YEAR-TO-YEAR CAP ON MEDICARE'S SECTION 223 COST LIMITS -- MOVED SO QUICKLY THROUGH CONGRESS.

THAT'S WHY THE HOUSE WAYS AND MEANS COMMITTEE AND THE SENATE FINANCE COMMITTEE DRAFTED A NEW HOSPITAL PROSPECTIVE REIMBURSEMENT PLAN THIS PAST SPRING.

THERE IS NO DOUBT IN MY MIND THAT CONGRESS IS COMMITTED TO PUTTING A LID ON WHAT THE FEDERAL GOVERNMENT PAYS FOR HEALTH CARE.

THE KEY DIFFERENCE BETWEEN THE SITUATION TODAY -- WITH TEFRA CONTROLS AND THE NEW DRG PAYMENT SYSTEM -- AND THE SITUATION A FEW YEARS AGO (WHEN THE CARTER HOSPITAL COST CONTAINMENT BILL WAS DEFEATED) IS THIS: THE DRG SYSTEM APPLIES TO MEDICARE ONLY, WHERE CARTER'S COST CONTAINMENT PLAN APPLIED TO ALL PAYERS, AND, THUS, REPRESENTED WHOLESALE REGULATION.

CONGRESS AND THE ADMINISTRATION WANT MEDICARE TO BE A PRUDENT BUYER FOR THE HEALTH SERVICES IT PURCHASES FROM HOSPITALS. FOR THE TIME BEING, FEDERAL POLICYMAKERS ARE WILLING TO LET BLUE CROSS, COMMERCIAL INSURANCE COMPANIES, BUSINESSES, AND PRIVATE-PAY PATIENTS FEND FOR THEMSELVES IN THEIR DEALINGS WITH HOSPITALS. TO THE EXTENT THAT THESE PARTIES ARE DISSATISFIED WITH HOSPITAL CHARGES, YOU CAN ANTICIPATE PRESSURE ON CONGRESS FOR INCREASED HOSPITAL REGULATION.

TEFRA/PROSPECTIVE REIMBURSEMENT

THE POINT I AM MAKING IS THAT CONGRESS IS INTERESTED IN LIMITING FEDERAL EXPENDITURES FOR HEALTH BY WHATEVER MEANS IT CAN FIND. CONGRESS WILL BE GUIDED LESS BY IDEOLOGICAL COMMITMENT TO REGULATION OR COMPETITION STRATEGIES THAN BY PRAGMATISM. IF AN APPROACH SAVES MONEY, CONGRESS WILL GIVE IT SERIOUS CONSIDERATION.

IT'S TIME EACH OF US STOPPED BLAMING THE OTHER GUY FOR THE HEALTH CARE COST PROBLEM. I THINK IT IS FAIR TO SAY THAT GOVERNMENT, CONSUMERS, PHYSICIANS, INSURERS, AND HOSPITALS ARE EACH RESPONSIBLE TO SOME DEGREE FOR THE COST PROBLEM WE HAVE TODAY. FOR THE MOST PART, WE'VE ONLY BEEN ACTING THE WAY THE SYSTEM ENCOURAGED US TO ACT.

THERE IS PLENTY OF ROOM FOR CHANGE. I THINK THE NEW DRG PAYMENT SYSTEM IS A FIRST STEP IN THE RIGHT DIRECTION. BUT MORE NEEDS TO BE DONE.

FOR EXAMPLE:

O WE NEED TO MAKE SURE THAT THE NEW DRG SYSTEM DOES NOT LEAD TO EXCESSIVE COST-SHIFTING. I KNOW MY COLLEAGUES ARE FOLLOWING THIS ISSUE CLOSELY. IF SUCH COST-SHIFTING DOES OCCUR, YOU CAN EXPECT GREATER PRESSURE FOR ALL-PAYOR RATE REGULATION.

THE QUESTION WILL BE: SHOULD THE REGULATION BE IMPOSED AT THE FEDERAL LEVEL OR ALLOWED TO DEVELOP AT THE STATE LEVEL?

O WE NEED TO ENSURE THAT THE DRG SYSTEM, WHICH CREATES INCENTIVES FOR ADDITIONAL HOSPITAL ADMISSIONS AND SOPHISTICATED TREATMENT, DOES NOT LEAD TO OVER-UTILIZATION, UNNECESSARY ADMISSIONS, AND "DRG CREEP."

I THINK PHYSICIAN PEER REVIEW CAN PLAY AN INVALUABLE ROLE

HERE AND I URGE YOU TO RECONSIDER YOUR OPPOSITION TO THE FEDERAL PHYSICIAN PEER REVIEW PROGRAM. THE LARGE EMPLOYERS AND COMMERCIAL INSURERS WHO ARE MOST CONCERNED WITH HOLDING DOWN THEIR HEALTH COSTS ARE COMMITTED TO THIS UTILIZATION REVIEW MECHANISM. THEY SPEND PRIVATE SECTOR DOLLARS FOR PHYSICIAN PEER REVIEW BECAUSE IT SAVES MONEY. IT IS GOOD BUSINESS. THAT'S A FAIR YARDSTICK BY WHICH TO MEASURE PUBLIC PROGRAMS.

O WE ALSO NEED TO MAKE SURE THAT THE DRG PAYMENTS MADE TO HOSPITALS ARE SET AT THE RIGHT LEVEL. THESE RATES SHOULD BE ALLOWED TO INCREASE FROM YEAR TO YEAR TO PERMIT THE DEVELOPMENT AND USE OF INNOVATIVE TECHNOLOGY. THE DRG CATEGORIES SHOULD BE PERIODICALLY RECALIBRATED.

I WAS SUCCESSFUL IN CONVINCING MY COLLEAGUES OF THE NEED FOR A PROSPECTIVE REIMBURSEMENT ASSESSMENT COMMISSION TO TAKE ON THIS JOB, AND I INTEND TO SEE THAT IT IS FUNDED. I KNOW THAT THE AHA SUPPORTS THIS COMMISSION. IF DRG PAYMENTS ARE POLITICIZED -- AND I FEAR THEY MAY BE -- HOSPITALS WILL BE UNDERPAID FOR THE SERVICES THEY PROVIDE.

O IN ADDITION, WE NEED TO MAKE SURE THAT PHYSICIANS' COSTS ARE ALSO ADDRESSED. I DON'T THINK VERY MANY PEOPLE REALIZE THAT MEDICARE PART B EXPENSES ARE INCREASING AT A FASTER RATE THAN PART A HOSPITAL EXPENSES. MORE WORK NEEDS TO BE DONE IN THIS AREA BEFORE WE TAKE LEGISLATIVE ACTION. BUT I DON'T MIND TELLING YOU THAT MANY OF MY COLLEAGUES WOULD LIKE TO SEE THE DRG SYSTEM EXPANDED TO INCLUDE PAYMENTS TO PHYSICIANS WHEN THEY PRACTICE IN

HOSPITALS.

FINALLY, WE NEED TO COME TO GRIPS WITH SOME VERY BASIC QUESTIONS CONCERNING ACCESS TO HEALTH CARE. WE NEED TO DECIDE WHAT THE PUBLIC ROLE SHOULD BE IN PAYING FOR CARE FOR THOSE WHO HAVE NO INSURANCE.

I KNOW THAT "FREE CARE" AND "BAD DEBT" HAVE A VERY REAL IMPACT ON YOUR HOSPITALS AND THEIR ABILITY TO REMAIN AFLOAT FINANCIALLY.

THE PROBLEM IS AGGRAVATED IN RURAL AREAS WHERE FEWER PEOPLE HAVE INSURANCE AND WHERE HOSPITALS ARE EXTREMELY DEPENDENT ON MEDICARE REIMBURSEMENT DOLLARS. I WISH I COULD TELL YOU WHAT THE FUTURE HOLDS IN THIS AREA, BUT I CANNOT.

I CAN ONLY SAY THAT THERE IS VERY GREAT COMPETITION FOR THE FEDERAL DOLLAR -- FROM THE NEED TO PROVIDE FOR NATIONAL SECURITY, TO THE NEED TO RETIRE THE DEFICIT, TO THE NEED TO MAINTAIN THE FEDERAL ROLE IN OTHER SOCIAL PROGRAMS.

SMALL RURAL HOSPITALS

BEFORE I LEAVE YOU TODAY, I WANT TO SHARE WITH YOU MY THOUGHTS ON HOW THE NEW DRG REIMBURSEMENT SYSTEM WILL AFFECT RURAL HOSPITALS. YOU MAY KNOW THAT I HAVE BEEN PARTICULARLY INTERESTED IN HOW "SOLE COMMUNITY PROVIDER" HOSPITALS ARE REIMBURSED BY MEDICARE.

FOR THOSE OF YOU NOT FAMILIAR WITH MONTANA, I SHOULD MENTION THAT 49 OF MONTANA'S 60 HOSPITALS HAVE FEWER THAN 100 BEDS. IN FACT, 45 OF THESE HOSPITALS HAVE FEWER THAN 50 BEDS, AND MOST ARE IN ISOLATED RURAL AREAS. THE PROBLEMS FACING RURAL HOSPITALS ARE A MAJOR INTEREST OF MINE. I PAY SPECIAL ATTENTION TO HOW MEDICARE POLICIES AFFECT THESE HOSPITALS.

TWO YEARS AGO, WHEN THE SECTION 223 COST LIMITS WERE SQUEEZED TO A LOWER LEVEL, I FOUND THAT THOSE MONTANA HOSPITALS THAT WERE ELIGIBLE FOR "SOLE COMMUNITY PROVIDER" EXEMPTIONS [FROM THESE LIMITS] WERE DENIED THEM.

I PERSONALLY INTERVENED IN THESE CASES, SECURED A GAO INVESTIGATION OF THE MATTER, AND GOT MOST OF HCFA'S DENIALS OVERTURNED. AND I WAS ABLE TO EXEMPT SMALL RURAL HOSPITALS WITH LESS THAN 50 BEDS FROM SECTION 223 COST LIMITS.

THE REAGAN ADMINISTRATION CAME TO WASHINGTON PROMISING TO REMOVE EXCESSIVE FEDERAL REGULATION AND TO BE RESPONSIVE TO LOCAL NEEDS. BUT I HAVE FOUND THAT SMALL COMMUNITY HOSPITALS -- THOSE WITH THE SMALLEST FINANCIAL, LEGAL, AND TECHNICAL RESOURCES TO WAGE A FIGHT AGAINST UNFAIR FEDERAL REGULATIONS AND POLICIES -- WERE THOSE THAT WERE MOST SUBJECT TO UNFAIR TREATMENT.

THIS PAST YEAR, DURING HEARINGS ON HHS'S PLAN FOR PROSPECTIVE PAYMENT, I REMINDED HHS OFFICIALS AND MY FINANCE COMMITTEE COLLEAGUES OF MY EXPERIENCE WITH HOW HCFA RAN THE

SECTION 223 PROGRAM. I FOUND THAT IT IS BETTER FOR CONGRESS TO DRAFT DETAILED LAWS THAN TO TRUST FEDERAL ADMINISTRATORS. I REFUSED TO ACCEPT SECRETARY SCHWEIKER'S PLEDGE THAT FEDERAL OFFICIALS WOULD TAKE CARE OF "SOLE COMMUNITY PROVIDERS'" SPECIAL NEEDS ON AN ADMINISTRATIVE CASE-BY-CASE BASIS.

I ARGUED FOR STATUTORY PROTECTIONS IN THE FINANCE COMMITTEE HEARINGS AND MARKUP SESSIONS, AS WELL AS IN THE HOUSE-SENATE CONFERENCE ON PROSPECTIVE PAYMENT.

I CAN TELL YOU THAT I WAS SURPRISED I DID NOT GET MORE SUPPORT FROM MY COLLEAGUES. THE PROTECTIONS I WROTE INTO THE PROSPECTIVE PAYMENT LEGISLATION ARE THE BEST I COULD GET FOR SMALL RURAL HOSPITALS. I HOPE THEY ARE SUFFICIENT.

IF A SMALL RURAL HOSPITAL EXPERIENCES A DROP IN UTILIZATION OF MORE THAN 5%, MEDICARE IS OBLIGED TO MAKE ADDITIONAL PAYMENTS TO THE HOSPITAL TO COMPENSATE IT FOR ITS ADDITIONAL COSTS. THE HHS SECRETARY DOES NOT MERELY HAVE DISCRETION TO ACT HERE -- HE IS OBLIGED TO ACT!

MY PAST EXPERIENCE WITH THE DISCRETION OF HHS OFFICIALS REGARDING "SOLE COMMUNITY PROVIDER" STATUS WAS ENOUGH TO PREVENT ME FROM GIVING IN TO HHS ON THAT POINT.

AND WHAT WILL THE FUTURE HOLD?

AS YOU KNOW, SMALL HOSPITALS WILL SOON BEGIN THE NEW DRG

SYSTEM -- SET TO BE PHASED-IN THIS FALL. SMALL RURAL HOSPITALS WILL ENTER THE FIRST YEAR OF THE "DRG PHASE-IN PERIOD" AND REMAIN THERE INDEFINITELY -- RECEIVING PAYMENT BASED 75 PERCENT ON THE HOSPITAL'S OWN COST EXPERIENCE AND BASED 25 PERCENT ON DRGs.

THE "SAFETY NET" OF A 5 PERCENT DOWNTURN IN UTILIZATION WILL BE IN PLACE. THIS WILL PROTECT "SOLE COMMUNITY PROVIDERS" FROM CONDITIONS BEYOND THEIR CONTROL -- LIKE STRIKES, FIRES, INABILITY TO RECRUIT PHYSICIAN STAFF, PROLONGED SEVERE WEATHER CONDITIONS, OR SIMILAR UNUSUAL OCCURRENCES WITH SUBSTANTIAL COST EFFECTS.

AND THESE HOSPITALS WILL HAVE A ONE-TIME OPTION OF VOLUNTARILY GIVING UP "SOLE COMMUNITY PROVIDER" STATUS AND ELECTING TO RECEIVE MEDICARE REIMBURSEMENT UNDER THE REGULAR DRG SYSTEM.

CONCLUSION

ONLY TIME WILL TELL US HOW WELL THESE SMALL HOSPITALS WILL FARE.

I HOPE THESE HOSPITALS PROSPER -- THE RESIDENTS OF SMALL TOWNS AROUND THE COUNTRY DESERVE IT.

LONGER