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American Group Practice Association (2)

Max S. Baucus

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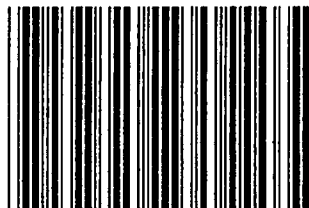
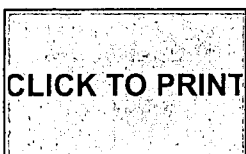
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BAUCUS

STATEMENT OF SENATOR MAX BAUCUS
AMERICAN GROUP PRACTICE ASSOCIATION
MARCH 23, 1984

INTRODUCTION

THANK YOU VERY MUCH FOR INVITING ME TO BE WITH YOU TODAY AT YOUR ANNUAL CONGRESSIONAL FORUM.

I AM GLAD THAT YOU HAVE COME TO WASHINGTON TO EXAMINE THE CHANGES THAT ARE TAKING PLACE IN AMERICA'S HEALTH INDUSTRY TODAY.

MEDICAL GROUP PRACTICES HAVE TO RESPOND TO CHANGE IN MANY AREAS OF HEALTH CARE. INCREASED COMPETITION AMONG HEALTH CARE PROVIDERS, INCREASED PRESSURE FROM BUSINESSES CONCERNED ABOUT COSTS, AND INCREASING PRESSURE FROM THE PUBLIC TO KEEP COSTS DOWN ARE GOING TO PUT THE UNWARY IN A BIND -- CAUGHT BETWEEN FINANCIAL PRESSURES AND THE DESIRE TO PROVIDE QUALITY, STATE-OF-THE-ART HEALTH CARE.

THE FEDERAL GOVERNMENT IS GOING TO BE A SOURCE OF CHANGE, TOO. I AM PLEASED TO HAVE THE OPPORTUNITY TODAY TO DISCUSS MY EXPECTATIONS FOR CONGRESSIONAL ACTION ON HEALTH ISSUES IN THE NEXT FEW YEARS.

I EXPECT CONGRESS TO FOCUS ON THE MEDICARE PROGRAM, WHICH IS APPROACHING INSOLVENCY WITHIN THE NEXT DECADE.

BUT TO START, LET'S 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.

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 \$322 BILLION. THAT'S OVER 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 THAT YEAR. AND THE COST OF PRIVATE HEALTH INSURANCE; ROSE 16 PERCENT IN 1982 -- THE BIGGEST INCREASE EVER.

RIISING HEALTH COSTS ARE A NATIONAL PROBLEM AFFECTING BOTH

THE PUBLIC AND THE PRIVATE SECTORS.

FEDERAL, STATE AND LOCAL GOVERNMENTS -- WHO PAY OVER 40 PERCENT OF THE HEALTH CARE BILL -- ARE RACKING UP RECORD BUDGET DEFICITS TO MEET THE SOARING COSTS OF MEDICARE AND MEDICAID.

INCREASED HEALTH EXPENDITURES AFFECT THE PRIVATE SECTOR BECAUSE WORKERS DRAW LOWER WAGES WHEN 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 CONGRESS ENACTED A NEW PROSPECTIVE PAYMENT SYSTEM
FOR HOSPITAL CARE UNDER MEDICARE.

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 WHOLESALERE 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. THERE WON'T BE ANY SACRED COWS -- SOME CHANGES WILL HAVE TO BE MADE NO MATTER WHO IS AFFECTED.

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:

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?

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. PEER REVIEW IS AN OLD TRADITION FOR GROUP PRACTICES, WHERE IT FOLLOWS NATURALLY AND IS ONE OF THE BEST GUARANTEES OF EFFICIENTLY DELIVERED, GOOD QUALITY CARE. I URGE YOU TO SUPPORT THE PHYSICIAN PEER REVIEW PROGRAM IN YOUR AREAS.

OF COURSE, 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. PHYSICIANS WHO PARTICIPATE CAN USE PEER REVIEW TO HELP ASSURE QUALITY SERVICES.

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. IF DRG PAYMENTS ARE POLITICIZED -- AND I'M AFRAID OUR RECENT EXPERIENCE WITH A DEFICIT REDUCTION PACKAGE INDICATES THEY WILL BE -- HOSPITALS WILL BE UNDERPAID FOR THE SERVICES THEY PROVIDE.

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 MUST TELL YOU THAT MANY OF MY COLLEAGUES WOULD LIKE TO SEE THE DRG SYSTEM EXPANDED TO INCLUDE PAYMENTS TO PHYSICIANS WHEN THEY PRACTICE IN HOSPITALS.

OUR EXPERIENCE OVER THE NEXT YEAR OR SO WITH THE NEW PROSPECTIVE PAYMENT SYSTEM FOR HOSPITALS WILL HAVE A CRITICAL EFFECT ON THAT DECISION.

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.

BUDGETS AND THE FUTURE

I CAN'T STRESS ENOUGH 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 ESSENTIAL SOCIAL PROGRAMS.

MEDICARE IS AFFECTED BY THAT COMPETITION. IN THE DEFICIT REDUCTION PACKAGE THAT HAS BEEN ASSEMBLED BY THE SENATE FINANCE COMMITTEE, THERE ARE \$9.4 BILLION WORTH OF CUTS IN HEALTH PROGRAMS OVER 3 YEARS; \$1.3 BILLION IN MEDICAID, AND NEARLY ALL THE REST IN MEDICARE.

THESE SAVINGS ARE ACHIEVED BY REQUIRING THE ELDERLY TO PAY SOME MORE, AND BY PAYING PROVIDERS A LITTLE LESS.

IF ENACTED, THESE PROPOSALS ARE GOING TO BE PAINFUL FOR MANY ELDERLY AMERICANS AND PAINFUL FOR MANY PROVIDERS.

MEDICARE SOLVENCY

BUT THIS \$9 BILLION PALES COMPARED TO THE SAVINGS WE ARE GOING TO HAVE TO FIND IN MEDICARE DURING THE COMING DECADE.

HEALTH CARE COSTS ARE CONTINUING TO INCREASE -- THE LABOR DEPARTMENT ANNOUNCED TODAY THAT THE COST OF HEALTH CARE ROSE

ANOTHER 8/10 OF ONE PERCENT IN FEBRUARY -- TWICE THE INCREASE OF GENERAL INFLATION.

CBO PROJECTS THAT THE MEDICARE TRUST FUND, WHICH FINANCES HOSPITAL CARE, WILL BE \$250 BILLION SHORT BY 1995.

UNFORTUNATELY, THERE AREN'T ANY MAGIC SOLUTIONS TO THE PROBLEM. WE HAVE THREE OPTIONS:

- 1) RAISE TAXES
- 2) REQUIRE THE ELDERLY TO PAY MORE
- 3) CONTROL COSTS

I THINK IT'S USEFUL TO KEEP IN MIND THE WAY THE SOCIAL SECURITY RETIREMENT PROGRAM WAS REFORMED LAST YEAR: WITH A BALANCED PACKAGE THAT SPREAD THE BURDEN. WE HAVE TO FIND THE SAME KIND OF BALANCED, EQUITABLE SOLUTION TO THE MEDICARE FINANCING CRISIS.

I CAN ASSURE YOU OF ONE THING: THE MEDICARE PROGRAM WILL STILL EXIST IN 10 YEARS. BUT IT WILL BE VERY DIFFERENT.

I DON'T KNOW WHAT IT WILL LOOK LIKE. BUT I AM CONFIDENT THAT CONGRESS WILL APPROACH THE PROBLEM PRAGMATICALLY, NOT IDEOLOGICALLY.

THE BURDEN IS BIG, AND IT MUST BE SHARED. NOBODY WILL BE IMMUNE. I EXPECT MEANS-TESTING PROPOSALS TO BE ON THE TABLE. AND THE SIZE OF THE MEDICARE DEFICIT MAKES IT VERY UNLIKELY THAT WE WILL BE ABLE TO AVOID RAISING SOME TAXES.

HERE ARE SOME OTHER PROPOSALS PUT FORTH ALREADY.

SENATOR DURENBERGER HAS PROPOSED A VOUCHER SYSTEM, TO "CASH OUT" MEDICARE AND GIVE THE ELDERLY VOUCHERS TO PURCHASE THEIR CARE.

SENATOR KENNEDY AND CONGRESSMAN GEPHARDT HAVE INTRODUCED A BILL THAT WOULD ESTABLISH A FEDERAL ALL-PAYER SYSTEM WHERE STATES HAVE NOT ESTABLISHED THEIR OWN COST-CONTROL SYSTEMS.

THE ADVISORY COUNCIL ON SOCIAL SECURITY, ALSO KNOWN AS THE BOWEN COMMISSION, HAS PROPOSED TO:

- O INCREASE TOBACCO AND ALCOHOL TAXES;
- O INCREASE THE ELIGIBILITY AGE FOR MEDICARE;
- O TAX EMPLOYER-PROVIDED HEALTH INSURANCE;
- O INCREASE COST-SHARING BY BENEFICIARIES;
- O RESTRICT PAYMENTS TO PROVIDERS;

FOR A TOTAL ESTIMATED SAVINGS OF \$203 BILLION BY 1995.

CONCLUSION

FOR MYSELF, I HAVE NOT EMBRACED ANY ONE APPROACH. BUT I DO

KNOW THAT SOLVING MEDICARE'S PROBLEMS IS CRITICAL, NOT JUST FOR THE SAKE OF THE ELDERLY BUT BECAUSE OF ITS IMPACT ON OUR ENTIRE HEALTH DELIVERY SYSTEM.

AS REPRESENTATIVES OF GROUP PRACTICES, YOU ALL KNOW THE BENEFITS OF GROUP PURCHASING -- YOU CAN BE EFFICIENT BY BUYING THINGS IN BULK, AND YOU HAVE LEVERAGE.

MEDICARE GIVES THE SAME KIND OF LEVERAGE. MEDICARE ACTS AS AN AGGRESSIVE THIRD PARTY PAYOR, LIKE A BIG INSURANCE COMPANY, FOR ITS CLIENTS.

WE ARE GOING TO HAVE TO BE MORE AGGRESSIVE IN THE NEXT FEW YEARS TO FIND A SOLUTION. I LOOK FORWARD TO WORKING WITH ALL OF YOU TO FORGE A SOLUTION THAT IS FAIR AND ONE THAT IS LASTING.

THANK YOU.