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## Health Care Costs

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BAUCUS

SENATOR MAX BAUCUS

SEPTEMBER 5, 1984

THE COST OF GETTING SICK IS BECOMING A NATIONAL CRISIS. HEALTH CARE COSTS MAY BE THE NUMBER ONE DOMESTIC ISSUE DURING THE 1980's.

HEALTH CARE IS ONE OF THE BASIC NECESSITIES OF LIFE. IN RECENT YEARS, WE HAVE WITNESSED GREAT STRIDES IN MEDICAL TECHNOLOGY, MAKING POSSIBLE THE CURE OR CONTAINMENT OF LIFE-THREATENING DISEASES. IN THE UNITED STATES, WE HAVE ALSO WITNESSED UNPRECEDENTED GAINS IN THE AVAILABILITY OF EXPERT HEALTH CARE TO ALL, ALMOST REGARDLESS OF THE ABILITY OF THE PATIENT TO PAY. AS A RESULT, PEOPLE ARE LIVING LONGER, HEALTHIER LIVES.

BUT THESE IMPROVEMENTS IN HEALTH CARE HAVE COME AT A PRICE. INCREASED HEALTH EXPENDITURES ARE STRAINING THE BUDGETS OF INDIVIDUALS AND GOVERNMENTS AT ALL LEVELS. IN 1970, HEALTH CARE COMPRISED 7.5 PERCENT OF THE GROSS NATIONAL PRODUCT, AND AMERICANS PAID AN AVERAGE OF \$358 A YEAR FOR HEALTH CARE. BY 1982, THE NATION'S MEDICAL BILL WAS \$32 BILLION, OR 10.5 PERCENT OF THE GROSS NATIONAL PRODUCT. AND EACH PERSON PAID ON AVERAGE \$1,365 FOR HEALTH CARE, NEARLY FOUR TIMES THE AMOUNT PAID JUST TWELVE YEARS EARLIER.

## HEALTH COSTS AND BUSINESS

AND, IT IS IMPORTANT TO RECOGNIZE THAT HEALTH CARE COSTS DIRECTLY CONTRIBUTE TO AMERICAN INDUSTRY'S LOSSES IN THE WORLD MARKETPLACE. U.S. STEEL, FOR EXAMPLE, ESTIMATES THAT THE COST OF HEALTH BENEFITS ADDS AN EXTRA \$20 TO THE PRICE OF EACH TON OF STEEL.

AND AMERICAN AUTO MAKERS FIGURE THE COST OF EMPLOYEE HEALTH BENEFITS AT \$600 ON EACH CAR PRODUCED. JOE CALIFANO, THE FORMER SECRETARY OF HEALTH, EDUCATION, AND WELFARE, TOLD ME EARLIER THIS YEAR THAT THE HEALTH COSTS OF CHRYSLER CORPORATION FOR ITS EMPLOYEES ARE FOUR TIMES WHAT THEY ARE FOR CHRYSLER'S JAPANESE COUNTERPARTS.

HE SAID THE MAJOR SUPPLIER FOR THE CHRYSLER CORPORATION IS NOT STEEL -- AS YOU WOULD EXPECT -- BUT BLUE CROSS AND BLUE SHIELD.

HIGH HEALTH COSTS AT HOME ARE MAKING IT MORE DIFFICULT FOR AMERICAN BUSINESSES TO COMPETE IN WORLD MARKETS, AND THE BUSINESS COMMUNITY IS BEGINNING TO RESPOND. LARGE CORPORATIONS AND MAJOR BUSINESS ORGANIZATIONS ARE EXPLORING SOME INNOVATIVE WAYS TO REDUCE THEIR OWN HEALTH EXPENDITURES, RANGING FROM EMPLOYEE WELLNESS PROGRAMS TO PREFERRED PROVIDER ARRANGEMENTS. AND, THEY ARE BEGINNING TO PUSH FOR MORE GENERAL COST-CONTROL ACTION BY STATE AND FEDERAL GOVERNMENTS.

## HEALTH COSTS AND MEDICARE

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

HEALTH CARE COST INFLATION IS BANKRUPTING MEDICARE. IN 1982 ALONE, FEDERAL OUTLAYS FOR MEDICARE JUMPED 21.5 PERCENT. SPENDING ON HOSPITAL CARE IS GROWING MUCH MORE RAPIDLY THAN THE INCOME DERIVED FROM FEDERAL PAYROLL TAX REVENUES.

BECAUSE OF THIS, THE CONGRESSIONAL BUDGET OFFICE PROJECTS THAT BEGINNING IN THE EARLY 1990'S, THE MEDICARE HOSPITAL PROGRAM WILL BE IN THE RED. BY THE YEAR 1995, THE CUMULATIVE DEFICIT COULD BE OVER \$200 BILLION.

A CLOSER EXAMINATION SHOWS THAT BETWEEN 1985 AND 1995, EXPENDITURES ARE EXPECTED TO GROW AT A 12.4 PERCENT ANNUAL RATE. AT THE SAME TIME, REVENUES WILL GROW AT ONLY A 7.9 PERCENT RATE, MUCH LESS THAN THE AMOUNT REQUIRED TO KEEP THE TRUST FUND SOLVENT.

AS THE SENIOR DEMOCRAT ON THE SENATE'S HEALTH SUBCOMMITTEE, WHICH HAS JURISDICTION OVER MEDICARE, I AM PARTICULARLY CONCERNED ABOUT THE EFFECT OF HEALTH CARE COST INFLATION ON THIS VITAL HEALTH INSURANCE POLICY FOR THE ELDERLY.

## DEFICIT REDUCTION BILL

EARLIER THIS SUMMER, CONGRESS PASSED LEGISLATION THAT WILL MAKE SEVERAL SIGNIFICANT CHANGES IN MEDICARE. THESE WERE INCLUDED IN A BILL THAT WILL REDUCE THE FEDERAL DEFICIT BY \$63 BILLION OVER THE NEXT THREE YEARS. I SERVED ON THE SENATE-HOUSE OF REPRESENTATIVES CONFERENCE COMMITTEE THAT WROTE THE FINAL VERSION OF THE BILL.

THE DEFICIT REDUCTION BILL WILL CUT MEDICARE'S COST BY \$7.1 BILLION FROM 1985 TO 1987. ONE BIG CHUNK OF THAT SAVINGS -- \$1.2 BILLION -- WILL COME IN THE FORM OF HIGHER MONTHLY PREMIUMS FOR COVERAGE UNDER MEDICARE PART B.

CONGRESS ALSO ENDORSED THE AMERICAN MEDICAL ASSOCIATION'S FREEZE PROPOSAL BY IMPOSING A 15-MONTH FREEZE ON WHAT DOCTORS ARE PAID FOR TREATING MEDICARE PATIENTS.

I STRONGLY OPPOSED SEVERAL PROVISIONS THAT WOULD HAVE FORCED MONTANA'S ELDERLY TO PAY A LOT MORE FOR HEALTH CARE, IN ADDITION TO THE INCREASED PREMIUMS. THESE PROVISIONS, WHICH INCLUDED PROPOSALS TO INCREASE PART B DEDUCTIBLES AND TO DELAY INITIAL ELIGIBILITY FOR MEDICARE, WERE DELETED FROM THE FINAL VERSION.

I SUPPORTED THE FINAL VERSION OF THE BILL -- BUT VERY RELUCTANTLY. I AM CONCERNED ABOUT WHETHER THE SANCTIONS ON DOCTORS MAY CAUSE SOME DOCTORS TO DROP COMPLETELY OUT OF MEDICARE. AND I AM CONCERNED ABOUT THE CUMULATIVE EFFECTS OF THESE PIECEMEAL CUTS ON THE ELDERLY.

#### LAB FEES PROVISION

ONE PROVISION I EXPECT YOU ARE CONCERNED ABOUT IS THE LIMITATION ON PAYMENTS FOR DIAGNOSTIC LABORATORY SERVICES. THE NEW LAW ESTABLISHES A NATIONAL FEE SCHEDULE FOR LAB FEES. THE INITIAL PAYMENT LEVEL FOR THE FEE SCHEDULE IS 60 PERCENT OF THE PREVAILING CHARGE LEVEL FOR INDEPENDENT LABS AND PHYSICIANS, AND 62 PERCENT FOR HOSPITAL OUT-PATIENT LABS.

THIS WAS ALL STARTED BY A GAO REPORT THAT TOLD CONGRESS THAT MEDICARE WAS PAYING TOO MUCH FOR LAB TESTS. THE MAJORITY OF LAB TESTS PAID FOR BY MEDICARE WERE DONE BY INDEPENDENT LABS, BUT THEY WERE USUALLY PURCHASED BY PHYSICIANS WHO TURNED AROUND AND BILLED MEDICARE THEMSELVES. AS ORIGINALLY CONCEIVED, THE LIMITATION ON LAB FEES WAS SUPPOSED TO PREVENT "MARKUPS" OF THE FEES.

MOST OF US ON THE SENATE FINANCE COMMITTEE RESISTED PROPOSALS TO EXTEND THE PROVISION TO HOSPITAL OUTPATIENT LABS. UNFORTUNATELY, MY SUBCOMMITTEE NEVER HAD AN OPPORTUNITY TO HOLD HEARINGS ON THE ISSUE.

ONE THING THAT PARTICULARLY DISTURBED ME ABOUT THIS PROVISION WAS THAT WE REALLY HAVE NO EMPIRICAL EVIDENCE TO JUSTIFY PEGGING THE RATE AT 60 OR 62 PERCENT OF PREVAILING CHARGES. THE SENATE CONFEREES INSISTED ON SETTING HOSPITAL FEES AT A HIGHER RATE THAN INDEPENDENT LABS, 62 PERCENT INSTEAD OF 60, MOSTLY BECAUSE OF A GENERAL FEELING THAT HOSPITALS TEND TO HAVE HIGHER FIXED COSTS TO COVER AND BECAUSE HOSPITALS WERE NOT IMPLICATED IN THE ORIGINAL GAO REPORT.

I ALSO RECOGNIZE THE ADDITIONAL ADMINISTRATIVE BURDEN THAT THIS PROVISION IS PLACING ON MONTANA HOSPITALS. IT PROBABLY SEEMS LIKE EVERY TIME YOU TURN AROUND, THE FEDERAL GOVERNMENT IS TINKERING WITH MEDICARE AND FINDING NEW FORMS FOR YOU TO FILL OUT.



TINKERING WITH MEDICARE: DRG RATE-SETTING

CONGRESS MUST ADDRESS THE FUNDAMENTAL PROBLEM FACING MEDICARE: SKYROCKETING HEALTH CARE COSTS. TINKERING WITH MEDICARE IS NOT AN EFFECTIVE WAY TO GUARANTEE ACCESS TO AFFORDABLE HEALTH CARE FOR ALL MONTANANS.

ONE RECENT EXAMPLE OF UNFORTUNATE "TINKERING" WITH MEDICARE WAS THE RECALCULATION OF DRG RATES.

AS PART OF THE DEFICIT REDUCTION BILL, CONGRESS VOTED TO TAKE AWAY PART OF THE PLANNED INCREASE IN DRG RATES. DRG'S WERE SUPPOSED TO INCREASE BY THE "HOSPITAL MARKET BASKET PLUS ONE PERCENT," WITH THE "1" INCLUDED TO COMPENSATE FOR ADDED TECHNOLOGY. IN PROPOSING TO TAKE AWAY PART OF THAT "1," WE WERE TRYING TO SPREAD THE BURDEN OF THE MEDICARE CUTS EQUITABLY -- WITH HOSPITALS, PHYSICIANS, AND THE ELDERLY ALL TAKING A SHARE.

THEN HCFA (THE HEALTH CARE FINANCING ADMINISTRATION) AND OMB (THE OFFICE OF MANAGEMENT AND BUDGET) GOT INTO THE ACT. AT ABOUT THE TIME THE DEFICIT REDUCTION BILL WAS IN CONFERENCE BETWEEN THE HOUSE AND THE SENATE, HCFA ANNOUNCED THAT THEY WERE RECALCULATING THE DRG RATES. THEY SAID THAT BASED ON NEW DATA THAT DEMONSTRATED LARGER-THAN-EXPECTED "DRG CREEP," THEY HAD TO RECALCULATE THE DRG WEIGHTS.

THIS MEANT THAT EFFECTIVELY, HCFA AND OMB WERE PLANNING TO CUT PAYMENTS TO HOSPITALS MUCH MORE THAN CONGRESS INTENDED WITH THE RELATIVELY MODEST CUTBACK ON THE DRG INFLATION RATE.

I HAVE SAID ALL ALONG THAT FOR THE PROSPECTIVE PAYMENT SYSTEM TO WORK, IT IS VITALLY IMPORTANT THAT HOSPITALS RECEIVE FAIR, PREDICTABLE PAYMENTS FOR THEIR SERVICES. WE SHOULDN'T TINKER WITH THE SYSTEM WHILE IT'S STILL BEING IMPLEMENTED.

THAT'S WHY I PUSHED HARD FOR THE CREATION OF THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION. THE COMMISSION WILL BE IN CHARGE OF REVISING AND UPDATING DRG RATES. THIS SHOULD KEEP THE PROCESS NON-PARTISAN, AND PROTECT HOSPITALS FROM ARBITRARY CHANGES IN DRG WEIGHTS AND PAYMENT RATES.

### TECHNOLOGY AND TOUGH CHOICES

THERE ARE SOME WHO SAY RISING HEALTH CARE COSTS ARE THE PRICE WE MUST PAY FOR LIVING LONGER AND CURING DISEASES. BUT THE TRUTH OF THE MATTER IS WE DON'T HAVE UNLIMITED RESOURCES. WE CAN'T CONTINUE TO PAY SUCH A HIGH PRICE FOR HEALTH CARE.

BUT NONE OF US WANTS TO RETURN TO THE "OLD DAYS." WE SHOULDN'T HAVE TO LIMIT THE ACCESS OF RURAL MONTANANS TO QUALITY HEALTH CARE. AND WE SHOULDN'T LIMIT THE AVAILABILITY OF NEW LIFE-SAVING TECHNOLOGY OR STOP SUPPORTING RESEARCH THAT CAN LEAD TO MEDICAL BREAKTHROUGHS.

BUT NEW MEDICAL TECHNOLOGY, DRUGS, PROCEDURES, AND DEVICES ARE RESPONSIBLE FOR NEARLY A THIRD OF THE ANNUAL INCREASE IN MEDICARE'S COSTS, ACCORDING TO A NEW STUDY. THIS STUDY, CONDUCTED BY THE CONGRESSIONAL OFFICE OF TECHNOLOGY ASSESSMENT, CONCLUDES THAT UNLESS SOME WAY IS FOUND TO BRING ABOUT MORE COST-EFFECTIVE USE OF BOTH EXISTING AND NEW MEDICAL TECHNOLOGIES, MEDICARE COSTS WILL CONTINUE TO SPIRAL OUT OF CONTROL.

COSTLY EXAMPLES CITED IN THE STUDY INCLUDE THE KIDNEY DIALYSIS PROGRAM, WHICH STARTED AT ABOUT \$250 MILLION TEN YEARS AGO AND NOW COSTS \$1.8 BILLION. ALSO CITED ARE CORONARY BYPASS OPERATIONS. OF THE APPROXIMATELY 50,000 PERFORMED ON MEDICARE PATIENTS IN 1982, OTA ESTIMATES THAT 15 PERCENT MAY HAVE BEEN OF LITTLE MEDICAL VALUE.

THE FINDINGS OF THE OTA SHOW THAT CONGRESS NEEDS TO MODIFY THE MEDICARE PROGRAM TO DEAL IN A MORE FLEXIBLE AND SOPHISTICATED WAY WITH MODERN MEDICAL TECHNOLOGY. BUT THE CHALLENGE OF THAT IS, TO FIND WAYS THAT DON'T LIMIT ACCESS OF MONTANANS TO AFFORDABLE, HIGH QUALITY HEALTH CARE.

THE COSTS AND AVAILABILITY OF MEDICAL TECHNOLOGY MUST BE ADDRESSED AS PART OF ANY LASTING SOLUTION FOR MEDICARE AND FOR OUR HEALTH SYSTEM IN GENERAL. IN ADDITION, WE WILL HAVE TO CONSIDER THREE OTHER MAJOR OPTIONS TO ADDRESS MEDICARE'S LONG-TERM FINANCING PROBLEM:

1) RAISING TAXES, WHETHER IT BE PAYROLL TAXES, EARMARKED TOBACCO OR ALCOHOL TAXES, OR SOMETHING ELSE;

2) REDUCING EXPENDITURES, WHICH COULD INCLUDE REDUCING PAYMENTS FOR SERVICES AND INCREASING COST-SHARING BY PATIENTS;

AND

3) CHANGING THE METHOD BY WHICH HOSPITALS AND OTHER PROVIDERS OF CARE ARE PAID, IN ORDER TO ENCOURAGE EFFICIENCY AND LOWER PRICES.

LAST YEAR CONGRESS TOOK A MAJOR STEP IN THE DIRECTION OF OPTION 3, BY ENACTING THE PROSPECTIVE PAYMENT SYSTEM. WE ALL HOPE THIS SYSTEM WILL ENCOURAGE HOSPITALS TO BECOME MORE EFFICIENT AND SAVE THE PROGRAM MONEY WHILE CONTINUING TO ASSURE QUALITY CARE FOR BENEFICIARIES.

BUT WE HAVE A LONG, LONG WAY TO GO. I CANNOT DO THE JOB ALONE. I AM COUNTING ON YOU AND OTHER HEALTH PROFESSIONALS IN MONTANA TO HELP ME IN THE MONTHS AHEAD. TOGETHER WE MUST FIND WAYS TO HELP STOP THE HEALTH CARE COST SPIRAL, GUARANTEE AFFORDABLE HEALTH CARE TO EVERY MONTANAN AND MAKE SURE FEDERAL REGULATIONS TREAT MONTANA'S HOSPITALS AND HEALTH CARE PROVIDERS FAIRLY.

THANK YOU.