REMARKS OF HENRY A. WAXMAN, CHAIRMAN
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
BEFORE THE
HOSPITAL MEDICAL STAFF CONFERENCE
AND THE
HOSPITAL TRUSTEE FORUM
NOVEMBER 15, 1982

I'M PLEASED TO HAVE THIS OPPORTUNITY TO JOIN YOU TODAY.

I'D LIKE TO START BY TRYING OUT A HOSPITAL ADMINISTRATOR JOKE ON YOU. IT'S BASED ON THE OLD "LIGHTBULB JOKE" FORMAT. FOR INSTANCE,

HOW MANY CALIFORNIANS DOES IT TAKE TO CHANGE A LIGHT BULB?

THREE: ONE TO CHANGE THE BULB, AND TWO TO SHARE THE EXPERIENCE.

NOW THAT YOU'VE GOT THE HANG OF IT, HOW MANY HOSPITAL ADMINISTRATORS DOES IT TAKE TO CHANGE A LIGHTBULB?

THE ANSWER?

FOUR:

-- ONE TO GET A CERTIFICATE OF NEED FOR A NEW BULB;

-- ONE TO FIGURE MEDICARE REIMBURSEMENT FOR THE PURCHASE;

-- ONE TO CONVINCE THE TRUSTEES THAT A BULB IS NEEDED; AND

-- ONE TO CONVINCE THE MEDICAL STAFF THAT A COMPUTERIZED BATTERY OF SEVENTEEN SPOTLIGHTS IS NOT NEEDED.

TODAY, HOWEVER, I WANT TO DISUCSS ISSUES ABOUT WHICH TRUSTEES AND SIAFF SHOULD AGREE. I'D LIKE TO TALK WITH YOU THIS MORNING ABOUT THE HEALTH CARE FINANCING ISSUES THAT THE NEW CONGRESS WILL CONFRONT.

FOR ME, THE BASIC QUESTION IS: WHAT WILL HAPPEN TO THE TWO MAJOR HEALTH ENTITLEMENTS -- THE MEDICAID PROGRAM FOR THE POOR, AND THE MEDICARE PROGAM FOR THE ELDERLY AND DISABLED?

OR PUT ANOTHER WAY, GIVEN THE IMBALANCE BETWEEN REVENUES AND OUTLAYS, HOW CAN THE FEDERAL GOVERNMENT ASSURE QUALITY HEALTH CARE FOR THE POOR, THE ELDERLY, AND THE DISABLED?

THE BEST WAY TO UNDERSTAND THE PROBLEM IS TO LOOK FOR A MOMENT AT THE FEDERAL HEALTH BUDGET.

THIS FISCAL YEAR, WE WILL SPEND ABOUT $85 BILLION ON HEALTH. BY FAR THE LARGEST PIECE OF THIS IS THE MEDICARE PROGRAM, WHICH WILL COST $56 BILLION. ANOTHER $20 BILLION WILL GO TO HELP THE STATES PAY FOR MEDICAID.

THAT LEAVES UNDER $10 BILLION FOR ALL THE OTHER FEDERAL HEALTH EFFORTS, RANGING FROM CHILDHOOD IMMUNIZATION TO NIH. IN FACT, THE INCREASE IN MEDICARE AND MEDICAID SPENDING FROM LAST YEAR TO THIS WILL NEARLY EQUAL THE AMOUNT SPENT ON ALL THE OTHER HEALTH PROGRAMS.

THE OTHER BASIC POINT TO UNDERSTAND ABOUT THE HEALTH BUDGET IS THAT, WHILE IT IS EXPECTED TO INCREASE BY $8 BILLION THIS YEAR, ALL OF THE INCREASE IS IN THE MEDICARE AND MEDICAID PROGRAMS. HEALTH RESEARCH WILL BE ONLY SLIGHTLY INCREASED, AND ALL OF THE SMALLER DISCRETIONARY PROGRAMS - LIKE CHILDHOOD IMMUNIZATION - WILL DECREASE.

NOW IT MIGHT SEEM AS THOUGH MEDICARE AND MEDICAID ARE FARING RATHER WELL. CERTAINLY THAT IS WHAT THE ADMINISTRATION WOULD LIKE US TO BELIEVE.

BUT AS THOSE OF YOU INVOLVED IN THE MANAGEMENT OF COMMUNITY HOSPITALS WELL KNOW, THESE PUBLIC PAYORS ARE NOT DOING SO WELL AT ALL.

YET, IN THE PERVERSE SCHEME OF REAGANOMICS, THE VERY FACT THAT THEY ARE STILL GROWING IN SIZE MEANS THAT THEY WILL BECOME PRIME TARGETS FOR ADDITIONAL CUTS NEXT YEAR. SENATOR DOLE, CHAIRMAN OF THE FINANCE COMMITTEE, HAS CALLED THE COMING FISCAL YEAR "THE YEAR OF HEALTH CARE CUTS."

THIS IS A BIT MYSTIFYING, SINCE THE PAST TWO YEARS HAVE SEEMED TO INVOLVE NOTHING BUT HEALTH CARE CUTS.

IN HIS FIRST BUDGET, PRESIDENT REAGAN PROPOSED THREE-YEAR MEDICARE AND MEDICAID CUTS OF $11 BILLION, INCLUDING A "CAP" ON FEDERAL MEDICAID PAYMENTS. WE FOUGHT THAT BUDGET TOTAL AS VIGOROUSLY AS POSSIBLE, BUT THERE WAS A CLEAR MAJORITY COMMITTED TO THE REAGAN BUDGET AND ECONOMIC PROGRAM.

EVEN SO, THE PRESIDENT WAS NOT SUCCESSFUL AT ENDING THE MEDICAID ENTITLEMENT. NOR DID HE GET ALL OF THE CUTS THAT HE WANTED. BUT HE WAS ABLE TO PUSH THROUGH ABOUT $6.5 BILLION IN MEDICAID AND MEDICARE CUTS OVER THREE YEARS.

THE MOST DEVASTATING WAS THE $3 BILLION MEDICAID CUT, LARGELY FROM A THREE-YEAR REDUCTION IN FEDERAL MATCHING PAYMENTS. THIS SEVERE COST SHIFT HAS BEEN A MAJOR CONTRIBUTOR TO THE ENORMOUS FISCAL PRESSURES ON STATES TO CUT THEIR PROGRAMS. I KNOW THAT A NUMBER OF YOUR INSTITUTIONS ARE ALREADY FEELING THE IMPACT IN LOWER REIMBURSEMENT RATES, REDUCED INPATIENT COVERAGE, AND TIGHTENED MEDICAID ELIGIBILITY.

BUT THAT WAS ONLY THE BEGINNING. IN HIS SECOND BUDGET, PRESIDENT REAGAN PROPOSED THREE-YEAR MEDICARE AND MEDICAID CUTS TOTALLING $24 BILLION. AGAIN, WE OPPOSED THAT BUDGET AS VIGOROUSLY AS POSSIBLE. AND AGAIN, THE PRESIDENT DID NOT GET ALL OF THE CUTS HE WANTED. BUT HE DID MANAGE TO ENACT A THREE-YEAR, $13 BILLION CUT IN MEDICARE AND MEDICAID AS PART OF THE TAX BILL THIS AUGUST.

THIS TIME, MEDICARE ABSORBED MOST OF THE LOSSES.

THE PROGRAM WAS CUT BY OVER $12 BILLION OVER THREE YEARS, WITH MOST OF THESE REDUCTIONS COMING FROM REIMBURSEMENTS TO HOSPITALS AND HOSPITAL-BASED PHYSICIANS. ROUGHLY HALF OF THE CUTS COME FROM NEW LIMITS ON MEDICARE HOSPITAL COSTS PER ADMISSION.

AND THE CONGRESS DIRECTED THE SECRETARY OF HEALTH AND HUMAN SERVICES TO DEVELOP A PROSPECTIVE REIMBURSEMENT PAYMENT METHOD FOR MEDICARE TO ACHIEVE ADDITIONAL SAVINGS IN THE FUTURE.

THE PATTERN THAT HAS EMERGED OVER THE LAST TWO YEARS IS FAIRLY CLEAR. MR. REAGAN WANTS TO "SAVE" THE FEDERAL GOVERNMENT MONEY BY SHIFTING COSTS SOMEWHERE - ANYWHERE ELSE.

IN MEDICAID, HE WANTS TO SHIFT THE COSTS TO THE STATES, THE COUNTIES, THE PROVIDERS, AND ULTIMATELY THE POOR.

IN MEDICARE, HE WANTS TO SHIFT THE COSTS TO THE PROVIDERS AND THE ELDERLY.

THIS COST-SHIFTING STRATEGY IS COMPLETELY ANTITHETICAL TO THE PURPOSE OF THESE PROGRAMS: THESE PROGRAMS WERE CREATED TO ASSURE ACCESS TO QUALITY HEALTH CARE FOR THE POOR, THE ELDERLY, AND THE DISABLED.

THE REAGAN PLAN DENIES ACCESS, FORCES REDUCTIONS IN QUALITY AND ULTIMATELY LEAVES PATIENTS TO FEND FOR THEMSELVES.

-- IT ENCOURAGES PROVIDERS TO DISCRIMINATE AGAINST PUBLIC PROGRAM PATIENTS.

-- IT ENCOURAGES THE DEVELOPMENT OF A TWO-CLASS SYSTEM OF MEDICAL CARE, ONE FOR PUBLIC PATIENTS, AND ONE FOR PRIVATE PATIENTS.

-- AND IT IS FUNDAMENTALLY UNFAIR TO THE BENEFICIARIES, THE PROVIDERS, AND THE TAXPAYERS.

YET PRESIDENT REAGAN HAS INSISTED THAT HE INTENDS TO "STAY THE COURSE." WE CAN, THEREFORE, EXPECT TO SEE MORE OF THE SAME FROM THE ADMINISTRATION IN THE BUDGET IT SUBMITS NEXT JANUARY: RENEWED ATTACKS ON THE MEDICAID AND MEDICARE ENTITLEMENTS AND CONTINUED DESERTION OF PATIENTS AND HOSPITALS.

WE DON'T KNOW PRECISELY WHAT FORM THESE PROPOSALS WILL TAKE. BUT LET ME TRY TO ANTICIPATE SOME OF THE DEBATE FOR YOU.

FIRST, THERE'S THE MATTER OF THE "NEW FEDERALISM." WE DON'T HAVE ALL OF THE DETAILS, BUT WHAT THE PRESIDENT SEEMS TO MEAN BY THIS IS A TRANSFER OF THE AID TO FAMILIES WITH DEPENDENT CHILDREN PROGRAM (AFDC) TO THE STATES IN EXCHANGE FOR FEDERAL ASSUMPTION OF THE MEDICAID PROGRAM.

WHEN YOU LOOK AT IT A LITTLE MORE CLOSELY, IT'S CLEAR THAT THE WHITE HOUSE IS NOT INTERESTED IN MANAGING THE MEDICAID PROGRAM. INSTEAD, THEY WANT TO GET THE FEDERAL GOVERNMENT OUT OF THE BUSINESS OF PAYING FOR HEALTH CARE FOR THE WORKING POOR -- THE MEDICALLY NEEDY POPULATION THAT MANY STATES NOW COVER. THIS WILL JUST MEAN MORE UNREIMBURSED PATIENTS FOR YOUR INSTITUTIONS.

MOREOVER, THE ADMINISTRATION WANTS TO END THE MEDICAID ENTITLEMENT TO LONG-TERM CARE FOR THE LOW-INCOME ELDERLY AND DISABLED. THE VEHICLE FOR THIS CHANGE WILL BE A LONG-TERM CARE BLOCK GRANT TO THE STATES, GIVING THEM LOTS OF FLEXIBILITY BUT INSUFFICIENT RESOURCES TO MEET THE INCREASING DEMAND FOR SUCH CARE. THE RESULT WILL BE REDUCED PAYMENTS TO NURSING HOMES, WHICH WILL IN TURN LEAD TO A TIGHTER SUPPLY OF BEDS FOR MEDICAID BENEFICIARIES, BACKING UP EVEN MORE OF THESE PATIENTS IN YOUR FACILITIES.

IN SHORT, "NEW FEDERALISM" IS NOTHING MORE THAN "THE OLD COST SHIFT."

ANOTHER ISSUE THAT IS LIKELY TO BE RAISED BY THE ADMINISTRATION IS WHAT THEY MAY CALL "MEDICARE REFORM." IT IS LIKELY TO INCLUDE INCREASED COST-SHARING FOR THE BENEFICIARIES, AND IT MAY EVEN INVOLVE MEANS TESTING.

BOTH OPTIONS ARE COMPLETELY UNACCEPTABLE.

LET'S START WITH THE QUESTION OF COST-SHARING. THE ADMINISTRATION PROBABLY FEELS THAT THE FEDERAL GOVERNMENT COULD "SAVE" MEDICARE DOLLARS BY IMPOSING A CO-INSURANCE REQUIREMENT ON THE FIRST 60 DAYS OF HOSPITAL CARE. AS YOU KNOW, UNDER CURRENT MEDICARE LAW THE BENEFICIARY IS RESPONSIBLE ONLY FOR THE $260 DEDUCTIBLE TO COVER THE FIRST DAY. THE NEXT 59 DAYS ARE NOT SUBJECT TO COST-SHARING.

IMPOSING A CO-INSURANCE REQUIREMENT ON BENEFICIARIES WOULD ONLY SUBJECT THEM TO AN UNNECESSARY, AND IN MANY CASES HARSH, FINANCIAL BURDEN. IT WOULD HAVE NO SIGNIFICANT EFFECT ON HOSPITAL UTILIZATION, SINCE THE DECISION TO ADMIT AND DISCHARGE IS NOT MADE BY THE BENEFICIARY AND IS ALREADY SUBJECT TO UTILIZATION REVIEW. AND HOSPITALS WOULD FIND THEIR BILLING AND COLLECTION TASKS MADE FAR MORE DIFFICULT, SINCE MANY OF THE ELDERLY WOULD NOT BE ABLE TO MAKE PAYMENT.

THE ONLY CONCEIVABLE REASON TO IMPOSE COINSURANCE ON HOSPITAL COVERAGE IS TO <u>TAX</u> THE BENEFICIARIES. YET THIS IS CONTRARY TO THE BASIC PURPOSE OF THE MEDICARE PROGRAM -- TO PROTECT THE ELDERLY AND DISABLED FROM THE HIGH COSTS OF MEDICAL CARE.

THE ARGUMENT WILL BE MADE: SOME OF THE ELDERLY ARE QUITE AFFLUENT AND CAN AFFORD TO PAY MORE FOR THEIR CARE. WHY DON'T WE INSIST THAT THEY PAY MORE BY IMPOSING INCOME-RELATED COST-SHARING?

THIS BRINGS US TO THE ISSUE OF MEANS-TESTING. IN ORDER TO RELATE CO-INSURANCE PAYMENTS TO INCOME, WE WILL HAVE TO KNOW THE INCOME OF EACH OF THE 29 MILLION MEDICARE BENEFICIARIES. THIS IS WHERE THE NIGHTMARE BEGINS.

FIRST, WE WILL HAVE TO DECIDE WHAT "INCOME" IS. DOES IT INCLUDE UNEARNED AS WELL AS EARNED INCOME? ARE SOCIAL SECURITY CHECKS, PRIVATE PENSION PAYMENTS, ANNUITIES, DIVIDENDS, MUNICIPAL BOND INTEREST, AND SIMILAR PAYMENTS INCLUDED IN INCOME?

NEXT, WE WILL HAVE TO DECIDE HOW MUCH INCOME A PERSON WILL BE ALLOWED TO KEEP BEFORE BEING EXPECTED TO PAY FOR HIS OR HER MEDICAL CARE. SHOULD EVERYONE WHO DOES NOT MEET THE OFFICIAL DEFINITION OF POVERTY BE EXPECTED TO PAY SOME AMOUNT? IF SO, HOW MUCH OF THEIR INCOME SHOULD THEY HAVE TO GIVE UP?

WE WILL THEN START TO WONDER WHY SOME PEOPLE, WHO HAPPEN TO HAVE MODEST INCOMES BUT SUBSTANTIAL ASSETS, SHOULD BE ALLOWED TO PAY SO LITTLE. SHOULDN'T A PERSON'S VACATION PROPERTY OR EXPENSIVE CAR BE TAKEN INTO CONSIDERATION IN DETERMINING WHETHER HE OR SHE IS ABLE TO AFFORD TO CONTRIBUTE TOWARD THE COST OF CARE?

WE WILL THEN NEED A BUREAUCRACY TO ADMINISTER THE RULES THAT WE DEVELOP, AND TO ENFORCE THOSE RULES AGAINST PEOPLE WHO MIGHT TRY TO DEFRAUD THE PROGRAM. SHOULD WE USE THE SOCIAL SECURITY ADMINISTRATION? THE IRS? STATE OR COUNTY AGENCIES? PRIVATE INSURERS? WHATEVER AGENCY WE USE, THE ADMINISTRATIVE COST WILL BE LARGE.

SOUND FAMILIAR? IT SHOULD. IT'S CALLED WELFARE MEDICINE. THE CLOSEST PARALLEL IS THE MEDICAID PROGRAM, A MEANS-TESTED HEALTH ENTITLEMENT. I DOUBT THAT ANY OF THE ELDERLY WHO HAPPEN TO BE ON THAT PROGRAM WILL TELL YOU THAT WE OUGHT TO MEANS TEST THOSE ON MEDICARE.

THE MEDICARE PROGRAM IS NOT A GIFT TO THE NATION'S ELDERLY. IT IS A SOCIAL INSURANCE PROGRAM. THE WORKING GENERATION PAYS TAXES THAT FINANCE THE MEDICAL EXPENSES OF THEIR PARENTS. WHEN THOSE NOW WORKING BECOME ELDERLY, THEIR CHILDREN WILL FINANCE THEIR HEALTH CARE. IT IS A SOCIAL COMPACT BETWEEN GENERATIONS.

MEANS-TESTING MEDICARE WOULD UP-END THIS SOCIAL COMPACT AND ERODE THE PUBLIC COMMITMENT TO FINANCING HEALTH CARE FOR THE ELDERLY. IT WOULD BE AN IRREVOCABLE AND DISASTROUS MISTAKE.

I FOR ONE WILL NOT BE PARTY TO ANY RENEGING ON THE PROMISES THAT MANY AMERICANS HAVE RELIED ON AS THEY GROW OLD.

NONETHELESS, THE MEDICARE PROGRAM <u>DOES</u> NEED IMPROVEMENT. I WILL DO EVERYTHING I CAN IN THE COMING CONGRESS TO ASSURE THAT CHANGES IN BOTH MEDICARE AND MEDICAID DO NO FURTHER HARM TO THE ELDERLY, THE DISABLED, AND THE POOR. I LOOK FORWARD TO WORKING WITH YOU IN THAT EFFORT.