REMARKS OF
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CHAIRMAN,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
BEFORE
THE AMERICAN FEDERATION OF HOME HEALTH AGENCIES
FEBRUARY 18, 1983

GOOD MORNING. I AM VERY PLEASED TO BE HERE TODAY TO DISCUSS SOME OF THE LEGISLATIVE PROSPECTS FOR HEALTH CARE IN THIS CONGRESS.

THE FIRST PROSPECT THAT I SEE IS THAT WE ONCE AGAIN FACE THE REAGAN ADMINISTRATION'S MILITARY APPROACH TO BAD BUDGET-MAKING IN HEALTH:

READY?

FIRE!

AIM.

FOR THE THIRD STRAIGHT YEAR, WE CONFRONT A BUDGET FROM THE PRESIDENT THAT SHOOTS DOWN HEALTH PROGRAMS COSTS BEFORE IT TARGETS SERVICES TO BE SAVED.

THE ADMINISTRATION CALLS FOR DEEP CUTS IN HEALTH PROGRAMS FOR THE ELDERLY, DISABLED, AND POOR--ALL TO REDUCE THE DEFICIT, BUT WITHOUT COUNTING THE LONG-TERM HEALTH AND HUMAN COSTS.

AS YOU KNOW, WE ARE FACING A DEFICIT OF ROUGHLY $200 BILLION. THAT DEFICIT COMES FROM THREE PLACES:

- FIRST, THE 1981 TAX CUT GAVE AWAY SOME $100 BILLION OF FEDERAL REVENUES. FEDERAL BORROWING FOR THIS HALF OF THE DEFICIT IS, IN FACT, BORROWING TO GIVE TAX BREAKS, THE ABSURD EXTREME OF SUPPLY-SIDE THEORY.

- SECOND, UNEMPLOYMENT COSTS THE NATION BILLIONS. THE ADMINISTRATION ESTIMATES THAT EVERY PERCENTAGE POINT OF UNEMPLOYMENT INCREASES THE DEFICIT BY MORE THAN $20 BILLION.

- FINALLY, DEFENSE SPENDING INCREASES HAVE GROWN TO THE POINT OF OFFENDING EVEN THE PRESIDENT'S TRADITIONAL ALLIES.

WHILE THOSE THREE FACTORS ARE CLEAR FROM ANY OBJECTIVE ANALYSIS OF THE BUDGET, THEY ARE NOT CLEAR TO THIS ADMINISTRATION.

THE WHITE HOUSE HAS IDENTIFIED THE PROBLEM, FOR THE THIRD YEAR IN A ROW, AS UNCONTROLLED DOMESTIC PROGRAM SPENDING. MEDICARE AND MEDICAID ARE TO BE CUT. PUBLIC HEALTH PROGRAMS ARE TO BE FROZEN AT ALREADY REDUCED LEVELS.

LET'S LOOK IN MORE DETAIL AT THEIR MEDICARE PROPOSALS. IN ESSENCE, THE ADMINISTRATION WANTS MEDICARE BENEFICIARIES TO PAY SIGNIFICANTLY HIGHER PREMIUMS AND HIGHER DEDUCTIBLES FOR PHYSICIAN CARE, AND HIGHER OUT-OF-POCKET PAYMENTS EVERY TIME THEY NEED HOSPITAL ATTENTION.

TWENTY-NINE MILLION ELDERLY AND DISABLED MEDICARE BENEFICIARIES WOULD PAY PREMIUMS FOR PHYSICIAN COVERAGE THAT WILL INCREASE BY 40 PERCENT OVER THE NEXT FIVE YEARS, AT A TOTAL COST TO THEM OF $8.2 BILLION.

THAT IS JUST THE INCREASED PREMIUMS. IF THE ELDERLY ACTUALLY NEED MEDICAL CARE, ITS EVEN WORSE. THE ANNUAL DEDUCTIBLE UNDER PART B, CURRENTLY $75, WOULD BE INDEXED TO INFLATION, SHIFTING MORE AND MORE COSTS TO THE ELDERLY AND DISABLED EVERY YEAR.

THE ADMINISTRATION ALSO PROPOSES TO FREEZE PHYSICIANS' FEES. BUT, AS YOU KNOW ALL TOO WELL, PHYSICIANS CAN CHOOSE NOT TO ACCEPT ASSIGNMENT AND CAN PASS THESE UNPAID CHARGES OVER TO THE PATIENT.

HOWEVER, THIS IS ONE AREA WHERE WE MAY BE ABLE TO TAKE SOME POSITIVE STEPS, AS OUR COMMITTEE DID LAST YEAR, BY DEVELOPING INCENTIVES FOR PHYSICIANS TO ACCEPT ASSIGNMENT. THAT WAY, WE COULD TRY TO BOTH REFORM THE REIMBURSEMENT SYSTEM AND PROTECT THE BENEFICIARIES. IT IS CLEAR, HOWEVER, THAT WE WILL HAVE TO CONTINUE TO DEVELOP THOSE INITIATIVES IN THE CONGRESS, BECAUSE THE PRESIDENT PROPOSES JUST A FLAT FREEZE.

THOSE MEDICARE BENEFICIARIES NEEDING INPATIENT HOSPITAL CARE WOULD CONFRONT EVEN HIGHER OUT-OF-POCKET COSTS, FOR THE ADMINISTRATION HAS COMBINED MORE HOSPITAL COINSURANCE WITH A SO-CALLED "CATASTROPHIC" BENEFIT THAT EXCLUDES MANY OF THE TRULY CATASTROPHIC EXPENSES THAT THE ELDERLY AND DISABLED CONFRONT, ESPECIALLY LONG TERM NURSING CARE.

THE INCREASED COST SHARING FOR THOSE IN NEED OF HOSPITAL CARE IS JUST A RECYCLED VERSION OF AN OLD FORD ADMINISTRATION PROPOSAL. THE INPATIENT DEDUCTIBLE WOULD CONTINUE, AND THEN THE BENEFICIARY WOULD PAY 8 PERCENT, OR $28 PER DAY, FOR THE 2ND TO THE 15TH DAY, AND 5 PERCENT, OR $17.50 PER DAY, FOR THE 16TH TO THE 60TH DAY. THE SKILLED NURSING FACILITY COPAYMENT WOULD BE REDUCED TO 5 PERCENT, OR $17.50 PER DAY.

- FOR THE AVERAGE STAY OF 11 DAYS, BENEFICIARIES WOULD PAY $280 MORE THAN THEY PAY UNDER CURRENT LAW;

- FOR EXTREMELY LONG STAYS, THEY WOULD PAY EVEN MORE -- AN ELDERLY PERSON NEEDING 50 DAYS OF CARE WOULD PAY ONE THOUSAND DOLLARS MORE THAN HE PAYS UNDER CURRENT LAW.

THE ADMINISTRATION HAS MADE A CLEVER EFFORT TO COUPLE THIS HIGHER COINSURANCE WITH A SO-CALLED "CATASTROPHIC" BENEFIT -- THEY ARE ELIMINATING COST SHARING FOR HOSPITAL CARE UNDER PART A AFTER 60 DAYS. ADMINISTRATION RHETORIC STRESSES THIS IMPORTANT PROPOSED NEW BENEFIT. IT IS AN IDEA THAT SOUNDS ATTRACTIVE, AND CATASTROPHIC PROTECTION IS LONG OVERDUE. BUT THE ELDERLY AND DISABLED ACROSS THE NATION SHOULD NOT BE MISLED BY THIS RHETORIC.

- THAT "CATASTROPHIC" COVERAGE WOULD NOT EXTEND TO PART B SERVICES FOR PHYSICIAN CARE, WHERE THE 20 PERCENT COINSURANCE WOULD CONTINUE WITH NO UPPER LIMIT.

- IN ADDITION, AS YOU KNOW, MEDICARE DOES NOT EVEN COVER MANY NEEDED SERVICES -- PRESCRIBED DRUGS, EYEGLASSES, HEARING AIDS, AND DENTAL CARE. PERHAPS MOST IMPORTANT TO THE ELDERLY AND THEIR FAMILIES, MEDICARE DOES NOT COVER LONG-TERM NURSING HOME CARE. THE ELDERLY'S PAYMENTS FOR THESE SERVICES WOULD CONTINUE AS UNDER CURRENT LAW.

SO WHAT THIS ADMINISTRATION PROPOSES ARE REALLY TWO THINGS:

FIRST, A RE-FINANCING SCHEME WHERE THE SICK ELDERLY PAY FOR THE CARE OF THE SICKER ELDERLY, (AND CONTRIBUTE ABOUT $6.3 BILLION ADDITIONAL TO FINANCE TAX CUTS AND DEFENSE SPENDING).

SECOND, A PROGRAM THAT PROVIDES "CATASTROPHIC" PROTECTION FOR ANYONE IN A HOSPITAL MORE THAN 60 DAYS WHO NEEDS <u>NO</u> PHYSICIAN SERVICES, <u>NO</u> OUTPATIENT DRUGS, AND <u>NO</u> LONG TERM CARE.

PRELIMINARY ANALYSES INDICATE THAT SOME 150,000 PEOPLE WOULD BENEFIT FROM THESE CHANGES -- THAT IS ABOUT <u>ONE-HALF OF ONE PERCENT</u> OF THE MEDICARE POPULATION. FOR EVERY <u>ONE</u> OF THOSE HELPED, <u>50</u> WOULD BE HURT AND PAY MORE COINSURANCE. MAYBE NOW WE SEE WHY THEY CALL IT CATASTROPHIC.

THE MEDICARE PROPOSALS ALSO INCLUDE A PROSPECTIVE REIMBURSEMENT SYSTEM. THIS IS A GENERAL IDEA THAT MANY OF US HAVE LONG ADVOCATED -- BUT WE NEED TO PROCEED WITH GREAT CARE BECAUSE HOSPITAL PAYMENTS ARE THE CORE OF THE MEDICARE BENEFIT, AND SERVE AS AN IMPORTANT COMPONENT OF THE NATION'S OVERALL FINANCING OF HOSPITAL SERVICES. OUR GOAL SHOULD BE TO REVISE THAT REIMBURSEMENT SYSTEM AND FINANCE CARE IN A MANNER THAT ENCOURAGES THE HOSPITALS TO PROVIDE HIGH QUALITY AND EFFICIENT CARE. THERE ARE A NUMBER OF ISSUES THAT WE NEED TO ADDRESS IN DEVELOPING SUCH A SYSTEM.

- THE CONGRESS WILL NEED TO CAREFULLY CONSIDER THE IMPLICATIONS OF SIMPLY SHIFTING MEDICARE COSTS TO PRIVATE INSURERS, TO STATES, AND TO LOCAL GOVERNMENTS. I MIGHT ADD THAT WE WILL <u>NOT</u> CONSIDER PROPOSALS TO PASS ON THOSE AMOUNTS TO THE PATIENT.

- WE MUST ADAPT ANY MEDICARE CHANGE TO ACCOUNT FOR HOSPITALS WITH UNIQUE CASELOADS AND FINANCING NEEDS BECAUSE THEY SERVE LARGE NUMBERS OF PUBLIC PATIENTS.

- WE MUST CONSIDER THE IMPACT OF MEDICARE CHANGES ON OUR EFFORTS TO FINANCE MEDICAL EDUCATION, AND TO ADDRESS APPROPRIATE CAPITAL NEEDS.

- WE MUST CONSIDER THE IMPACT OF THE PROPOSAL ON THE DEVELOPMENT OF NEW TECHNOLOGY.

- WE WILL NEED TO CAREFULLY CONSIDER INCENTIVES TO STATES TO CONTINUE TO DEVELOP SUCCESSFUL STATEWIDE PROGRAMS IN LIEU OF MEDICARE ONLY APPROACHES.

IF WE DO NOT CONFRONT THESE ISSUES, THERE IS A RISK THAT CHANGES IN MEDICARE ALONE, COUPLED WITH CHANGES ALREADY IN PLACE IN MEDICAID, WILL MOVE US TOWARD A TWO TRACK SYSTEM OF CARE -- ONE FOR THE ELDERLY AND POOR, AND ANOTHER FOR THE REST OF THE NATION.

FINALLY, THE ADMINISTRATION ONCE AGAIN PROPOSES TO CHANGE MEDICARE INTO A VOUCHER PROGRAM.

NOBODY CAN TELL YOU WHY BENEFICIARIES SHOULD WANT THESE VOUCHERS.

NOBODY CAN TELL YOU WHAT TYPE OF INSURER OTHER THAN HMO'S WILL COMPETE FOR THE VOUCHERS.

NOBODY CAN TELL YOU WHAT HAPPENS UNDER A MEDICARE CAPITATED SYSTEM, BECAUSE WE HAVE NO NATIONAL MEDICARE EXPERIENCE ON A PREPAID BASIS.

NEVERTHELESS, THE ADMINISTRATION REMAINS COMMITTED TO THE CONCEPT OF TURNING MEDICARE OVER TO THE PRIVATE SECTOR. I ASSURE YOU THAT I REMAIN EQUALLY COMMITTED TO PRESERVING MEDICARE AS A NATIONWIDE PROGRAM OF SOCIAL INSURANCE.

IF SOMEDAY WE LEARN OF SOME TYPE OF SUCCESSFUL ORGANIZATION OTHER THAN AN HMO TO WHICH WE CAN CONFIDENTLY EXTEND CAPITATION, THEN WE SHOULD CONSIDER IT. BUT UNTIL THEN, PROPOSALS FOR VOUCHERS ARE UNACCEPTABLE.

MEDICAID IS ANOTHER MAJOR HEALTH PROGRAM WHICH CONTINUES TO SUFFER UNDER THE ADMINISTRATION'S BUDGETARY POLICIES. CONGRESS MADE MATCHING REDUCTIONS IN THE 1981 RECONCILIATION BILL, AND EXTENDED THOSE REDUCTIONS FOR THREE YEARS, THROUGH FISCAL YEAR 1984. NOW THE ADMINISTRATION WANTS TO EXTEND A THREE PERCENT REDUCTION PERMANENTLY -- SIMPLY CONTINUING A SHIFT OF COSTS TO STATES AND LOCAL GOVERNMENTS THAT CAN ILL-AFFORD IT. SUCH A POLICY COMPOUNDS THE PRESSURES ON STATES TO CUT ELIGIBILITY, BENEFITS, AND REIMBURSEMENT BELOW THEIR ALREADY REDUCED LEVELS -- AN OUTCOME THAT NONE OF US CAN ACCEPT.

IN ADDITION TO THIS MATCHING REDUCTION, THE ADMINISTRATION AGAIN PROPOSES MANDATORY COST SHARING UNDER EVERY STATE MEDICAID PROGRAM. THIS WAS A PROPOSAL THAT WE MANAGED TO DEFEAT LAST YEAR, BUT LIKE THE REST OF THEIR POLICIES, IT KEEPS COMING BACK AGAIN AND AGAIN.

I KNOW THAT THERE IS ANOTHER ISSUE WHICH IS OF CONCERN TO YOU AND YOUR MEMBERS -- LONG-TERM CARE FOR THE CHRONICALLY ILL. SINCE BECOMING CHAIRMAN OF THE SUBCOMMITTEE, MY STAFF AND I HAVE BEEN CONSTANTLY GRAPPLING WITH THAT QUESTION, AND I FEEL WE HAVE MADE SOME POSITIVE CONTRIBUTIONS.

PERHAPS THE MOST PROMISING ACCOMPLISHMENT OF THE BUDGET FIGHTS OF THE LAST CONGRESS WAS THE PASSAGE OF A PROPOSAL THAT CONGRESSMAN PEPPER AND I HAD WORKED ON FOR SOME TIME: THE MEDICAID COMMUNITY CARE WAIVER.

I'M SURE THAT MANY OF YOU ARE FAMILIAR WITH THE PROGRAM, BUT LET ME DESCRIBE THIS OPTION.

THE COMMUNITY CARE WAIVER IS INTENDED TO ALLOW STATES TO DESIGN THEIR OWN FRAMEWORK FOR SERVING PEOPLE IN INSTITUTIONS AND AT RISK OF INSTITUTIONALIZATION. THE PROVISION PERMITS STATES TO OFFER AN ARRAY OF HOME AND COMMUNITY-BASED SERVICES AS AN ALTERNATIVE TO NURSING HOME CARE--AND TO RECEIVE MEDICAID PAYMENTS FOR THESE SERVICES.

I AM EXCITED BY THE POSSIBILITIES OF THIS PROVISION. WE NOW HAVE A FINANCING SYSTEM THAT INADVERTENTLY ENCOURAGES USE OF ONLY THE MOST EXPENSIVE FORM OF LONG-TERM CARE WHILE DISCOURAGING FAMILIES THAT WOULD LIKE TO CARE FOR THEIR DISABLED CHILDREN OR RELATIVES AT HOME. IT IS IMPORTANT THAT WE BEGIN TO DEVELOP REIMBURSEMENT PROGRAMS AND DELIVERY SYSTEMS THAT ALLOW PEOPLE TO LIVE OUTSIDE OF INSTITUTIONS.

A NUMBER OF STATES HAVE BEGUN TO TAKE ADVANTAGE OF THIS CHANCE TO OFFER RESPONSIBLE ALTERNATIVES TO THE DISABLED AND THE ELDERLY. AT LAST COUNT 56 WAIVERS HAD BEEN REQUESTED AND 26 HAD BEEN APPROVED.

WE IN THE CONGRESS WILL BE FOLLOWING THE EXPERIENCE UNDER THESE WAIVERS VERY CLOSELY. I AM CONCERNED ESPECIALLY THAT STATES NOT USE THE COST SAVINGS OF COMMUNITY PROGRAMS TO DIVERT THEIR RESOURCES AWAY FROM THE DISABLED AND INTO HIGHWAY TRUST FUNDS AND LOWER PROPERTY TAXES. THE COMMUNITY CARE WAIVER--WHILE INTENDED TO REDUCE COSTS--IS PRIMARILY DIRECTED TOWARD IMPROVING SERVICES FOR THE ELDERLY AND DISABLED.

FROM THESE EXPERIMENTS WE NEED TO LEARN HOW THE FLOW OF MEDICAID DOLLARS INTO HOME AND COMMUNITY-BASED CARE AFFECTS THE HEALTH AND WELL-BEING OF BENEFICIARIES. WE NEED TO LEARN IF NEW ARRANGEMENTS ARE DEVELOPED BY COMMUNITIES AND PRIVATE PROVIDERS TO RESPOND TO THE NEED FOR ALTERNATIVE SERVICES. AND WE NEED TO LEARN HOW MUCH SUCH OPTIONAL PROGRAMS COST.

IN OTHER AREAS OF LEGISLATION, I WOULD ALSO POINT OUT TO YOU THAT EVEN SOME OF THE MOST HARDENED BUDGET CUTTERS AMONG THE REPUBLICANS HAVE REALIZED THAT HOME HEALTH IS WORTH FEDERAL INVESTMENT.

TWO YEARS AGO, THE ADMINISTRATION CAME TO THE HILL ASKING FOR US TO REPEAL THE GRANTS PROGRAMS FOR HOME HEALTH AGENCIES. WE IN THE HOUSE OPPOSED SUCH A REPEAL, BUT THE SENATE ACCEPTED ALMOST ALL OF THE ADMINISTRATION'S PROPOSALS. THE COMPROMISE BILL FINALLY REPEALED THE PROGRAM.

THIS PAST YEAR, HOWEVER, SENATE REPUBLICANS CAME BACK WITH A PROPOSAL TO PROVIDE GRANTS AND LOANS FOR THE ESTABLISHMENT OF HOME HEALTH AGENCIES AND FOR HOME HEALTH TRAINING. THAT PROVISION WAS FINALLY ADDED TO MY PROPOSAL FOR ORPHAN DRUGS AND WAS EVENTUALLY SIGNED BY THE PRESIDENT.

I CAN ONLY HOPE THAT THE SENATE REPUBLICANS WILL SHOW THE SAME SORT OF CHANGES OF HEART OVER OTHER HEALTH AUTHORITIES THROUGHOUT THIS CONGRESS.

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BUT ADDING MEDICAID COVERAGE FOR HOME-BASED SERVICES AND GRANTS FOR HOME HEALTH AGENCIES ARE ONLY A PART OF THE LONG-TERM CARE ISSUE. WE ARE STILL CONFRONTED WITH THE PERPLEXING PROBLEM OF HOW TO FINANCE SUCH CARE, SO THAT ITS COSTS REMAIN WITHIN REASONABLE BOUNDS AND ITS STANDARDS ARE HIGH.

AS YOU KNOW, SEVERAL PROPOSALS HAVE BEEN PUT FORWARD FOR LONG-TERM CARE FINANCING. THESE INCLUDE ADDING A NEW TITLE TO THE SOCIAL SECURITY ACT, WITH A SPECIFIC LONG-TERM CARE BENEFIT. ANOTHER SUGGESTS ADDING A PART C TO MEDICARE FOR THIS PURPOSE. SOME HAVE SUGGESTED A NEW KIND OF IRA, FOR LONG-TERM CARE COVERAGE. EACH OF THESE IDEAS HAS MERIT AND EACH HAS DEFICIENCIES. I PROPOSE TO SPEND TIME THIS SESSION IN ANALYZING THESE AND OTHER IDEAS, GETTING THE BEST ADVICE POSSIBLE ON THIS ISSUE, AND TRYING TO DEVELOP A BILL WHICH WOULD MAKE SENSE OF OUR CURRENT NON-SYSTEM OF LONG-TERM CARE.

I HAVE ALREADY HAD ONE MEETING WITH A GROUP OF HEALTH ECONOMISTS, AND AM PLANNING SEVERAL MORE WITH OTHER EXPERTS IN THE FIELD. AGAIN, THIS IS AN AREA WHERE YOUR OWN EXPERIENCE OFERS US MUCH TO THINK ABOUT, AND I URGE YOU TO LET ME AND MY STAFF KNOW SOME OF YOUR IDEAS.

IT IS A MASSIVE UNDERTAKING, TO TRY AND DEVELOP A REAL SYSTEM OF LONG-TERM CARE WHICH HOLDS COSTS DOWN, PROVIDES APPROPRIATE SERVICES TO THOSE WHO REALLY NEED THEM, AND STRENGTHENS RATHER THAN REPLACES EFFORTS FAMILIES NOW MAKE IN CARING FOR THE ELDERLY. JOIN ME IN THIS ENDEAVOR.

THE HEALTH NEEDS IN OUR SOCIETY, AND ESPECIALLY THE NEEDS OF THE POOR, THE ELDERLY AND THE DISABLED, NEED TO BE ADDRESSED IN A REALISTIC, THOUGHTFUL WAY. FUNDS MUST BE APPROPRIATED TO MEET THOSE NEEDS, AND SPENT IN A RESPONSIBLE, ACCOUNTABLE MANNER. IT IS NOT EASY TO PROVIDE HIGH LEVEL APPROPRIATE CARE WHILE HOLDING DOWN EVER-ESCALATING COSTS. YET THAT IS EXACTLY WHAT WE MUST DO IF WE ARE TO RISE TO THE CHALLENGE OF THE CHANGING DEMOGRAPHICS OF THE NEXT 50 YEARS.

I URGE YOU TO JOIN ME IN THAT EFFORT.