REMARKS OF

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BEFORE THE

LAB INSTITUTE '86

SEPTEMBER 12, 1986

I am pleased to be able to come before you this morning, to discuss the federal role in health care. You have come to Washington at a very opportune time to observe the Congress -- at its best or its worst, depending on your point of view -- trying to grapple with heady issues, within unrealistic time limits and budgetary constraints.

We have just begun what is scheduled as a four week session. During this period, we are supposed to reach final agreement on a full menu of issues, including:

-- appropriations for the next fiscal year

-- tax reform

-- an increase in the debt ceiling

-- budget reconciliation

-- meeting the Gramm-Rudman deficit reduction target

-- sanctions against South Africa

-- drug abuse

-- trade reform

-- [illegible] reform

-- confirmation of Supreme Court justices, and

-- impeachment of a federal judge

It should be an entertaining session -- for you, if not for me.

THE POLITICS OF DEFICIT REDUCTION

The key message I have for you this morning is that the politics of deficit reduction will be dominant throughout this session. This has been the case for the last several years and will continue to be the case for the foreseeable future. It is not a pleasing prospect.

Last March, when we finally enacted the 1985 budget reconciliation bill (COBRA), and the mandatory Gramm-Rudman budget cuts for 1986 went into effect, the fiscal year 1986 deficit was supposed to be less than $172 billion. We are now told it will exceed $230 billion.

Last July, we adopted a budget resolution that would have brought the fiscal year 1987 deficit below the Gramm-Rudman target of $144 billion. Unfortunately, we failed to pass the requisite budget reconciliation prior to August 15. That is the date on which the Office of Management and Budget and the Congressional Budget Office took their "snapshot" estimates of the FY 87 deficit. Their estimates showed that the deficit would exceed the Gramm-Rudman target by more than $19 billion.

CBO and OMB estimated that, as things stand now, we would need across-the-board cuts -- or sequestrations, in the parlance of Gramm-Rudman -- of 7.6% in domestic programs and 5.6% in defense programs in order to get the deficit down to the Gramm-Rudman target.

Nobody -- not you, not me, and not the President -- wants to have indiscriminant cuts of this kind. However, to avoid them, we would have to make selective cuts in the budget of more than $9 billion. That will obviously not be an easy task, because there is so little agreement on how such cuts should be made. Everyone has his or her own priorities and candidates for reductions. The President still insists that we increase, rather than cut, defense; that we not raise taxes; and that we not touch Social Security. Doing it with mirrors, unfortunately, is also not an option.

THE DILEMMA FACING US NOW

Our package of budget reconciliation proposals, adopted by the various committees in July, will not achieve sufficient savings to meet the Gramm-Rudman target. In fact, we are farther from meeting the target through reconciliation today than we were before we recessed for Labor Day.

The budget resolution adopted in July called for cuts in Medicare of $600 million in FY 1987 and $3.3 billion over three years. The reconciliation proposals adopted by the Energy and Commerce Committee and by the Ways and Means Committee met -- and exceeded -- those

targets. We were able to do so because we were being measured against a budget baseline that took into account the statutes and regulations in effect last February.

This meant that we could take some of the Administration's budget proposals that we did not fully endorse, modify them to temper their impact on beneficairies and providers, and still achieve savings. Examples include the increase in hospital PPS rates, periodic interim payments (PIP) for hospitals, and payment rates for kidney dialysis services.

We were also able to reject outright those Administrative proposals that simply shifted costs to the beneficiaries -- such as an increase in the Part B deductible, imposition of new copays, and a one-month delay in eligibility. And, we were able to include various program improvements that increase the cost of the program modestly -- such as judicial appeals under Part B, vision care, coverage of immunosuppressive drugs, and expanded research on physician practice patterns.

All this, and we were still able to make our savings targets.

Then, in August, the ground shifted under us.

Since the real objective of the reconciliation process is to meet the Gramm-Rudman deficit reduction target, we are now measuring our reconciliation proposals against a new baseline -- one that takes into

include [illegible] rates, PIP, and dialysis rates.

account the statutory and regulatory changes between February and August 15. As a result, several provisions that were previously scored as savings are now scored as spending. The net shift exceeds $2 billion in Medicare alone, and the total reconciliation package falls far short of the target.

We are being hit with a double whammy.

At the same time that CBO, OMB, and GAO are telliing us that the deficit is larger than we previously thought, we also have fewer opportunities to make the budget cuts aleady assigned to us.

POSSIBLE SOLUTIONS

How will we manage our way out of this dilemma?

I wish I could answer that question for you. I would be glad to share the answer with you if I knew it.

Matters are very unsettled now and very fluid. I assume that we will be re-examining all of the provisions in our reconciliation package, to see whether they can be modified to achieve greater savings.

I sincerely hope that ~~we~~ our targets for saving in Medicare and the other health programs will not be increased. Rather, the short fall in achieving the Gramm-Rudman target should be achieved by

finding increased revenues. Possible sources might include the sale of Conrail, or increased excise taxes on liquor or other commodities. I will certainly be arguing that position as firmly as I can.

Even if that is the case, however, there will be enormous pressure on us to drop or modify the various program improvements that I referred to earlier and to find savings anywhere else that we can. No nook and cranny of the Medicare program will be beyond scrutiny.

I do know this much: no matter how well we fare this year in meeting the Gramm-Rudman target through budget reconciliation, the taks will be even harder next year when the deficit target is reduced to $108 billion.

I also know this: al long as we concentrate all our attention and energy on reducing the beudget deficit for the current year, we will not be paying sufficient attention to many other important considerations and issues.

We have been worrying too much about <u>how much</u> we pay for Medicare services, and not enough about <u>what</u> we are paying for.

-- Is it the right service?

-- Is it delivered by the most appropriate provider in the most appropriate setting?

-- Does it meet our expectations and standards for quality?

We should have been paying more atention to these issues in the past, and we must do so in the future. You will see some beginning efforts in this direction in the reconciliation package. These include a study by the Institute of Medicine on quality of care; expansion of PRO activities into ambulatory settings and putting greater emphasis of quality assurance, as opposed to utilization review; and expanded research on physician practice patterns and patient outcomes.

RECONCILIATION ITEMS BEARING ON CLINICAL LABS

Let me turn briefly to the provision in the House reconciliation package of most immediate concern to you -- namely the changes in the clinical laboratory fee schedule.

I know that you have a panel of knowledgeable experts following me on the program who are prepared to discuss these provisions in detail ~~and~~ I will not try to preempt that discussion.

I think you should view these changes essentially as following through on the initiative begun two years ago with DEFRA. We sought then to initiate a reform in Medicare payments that would simplify and rationalize the Medicare payment system, as well as to achieve whatever savings were appropriate from incouraging more cost-effective delivery of services. It was, and should still be, viewed as one of a series of reforms that we want to undertake throughout the Medicare

program.

We started with the notion that all laboratory services should be treated alike, regardless of the type of laboratory that did the actual testing. However, concerns were raised by various parties which, in the absence of better information, experience or crystal balls, led us to modify that objective. Thus, we provided higher payments for hospital laboratories, than for independent labs or physician office labs. In addition, we required assignment on all claims for testing done by independent labs, ~~we~~ but did not do so for physician office labs. We also recognized that there would be wide geographic variations in the fee schedules, but concluded that we should tolerate them initially, and should move cautiously in bringing about major changes in the delivery of laboratory services.

Earlier this year, in COBRA, we dealt with some of these issues. We instituted caps on the local fee schedules, to iron out some of the geographic variations. We also required assigment for testing done by physician office labs.

In the reconciliation package currently pending before the Congress, we ~~have brought~~ would bring the hospital lab fee schedules into line with those for independent labs and physician office labs. That is, we ~~have~~ would remove the 2 percent differential for hospital labs that we put in DEFRA and remove the sunset provision, under which hospitals would have reverted to cost-based reimbursement.

In addition, we ~~decided to~~ would postpone indefinitely the changeover to a national fee schedule that ~~was~~ is due to take place on January 1, 1988. It seems more prudent, at this time, to examine the effects of the caps imposed under COBRA -- as well as the effects of the fee schedule provision as a whole -- before making a final decision about a national fee schedule. We will be receiving reports from the Comptroller General and from the Secretary of HHS regarding the impact of the fee schedule provision so far and the likely impact of a national fee schedule. We look forward to those studies and will examine them carefully before making other major changes in the provision.

Again, let me say it is a pleasure to be here and to share these observations with you. Thank you very much.