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NATIONAL COUNCIL ON AGING

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Ladies and gentlemen. Good morning. I know that many of you expected to see the Democratic Presidential candidates here this morning, and I hope you can see that we're all not Democrats and we didn't plan on holding a debate.

But what if there were a debate this morning, with the candidates limited to just one issue related to aging policy? Which issue would you select? I want you to take this question seriously. There are so many unmet needs and unanswered questions, we'll need some priorities if we want to effectively deal with any of them.

What about the issue of mandatory retirement? I hope all of the candidates would want to eliminate, once and for all, the arbitrary practice of equating a person's right to work with the number of candles on his birthday cake. And with so few members of the current "baby bust" generation available to join the workforce in coming years, we're going to have to do a better job of retaining our more experienced workers in order to sustain economic growth in this nation.

What about the question of housing for the elderly? We don't have an adequate national policy or program to meet the needs of millions of older Americans who cannot afford to pay their rents or maintain their own homes. Neither do we have answers to the dilemma posed by housing projects, whose residents are "aging in place". These housing projects are, in effect, becoming nursing homes without services. Shouldn't we address this issue now, before it gets any worse?

And then there's the need for research and health education. Americans health problems are changing as we live longer. We have made an enormous national commitment to treatment of people with acute diseases, such as heart problems, but we continue to skimp in the treatment of chronic problems such as arthritis. We may have begun to win the war on cancer, but we haven't even begun the battle against Alzheimer's Disease. We've come to recognize the tremendous human costs of our failure to meet the long term care needs of the chronically ill. Shouldn't this be the principal challenge for the next Administration to address?

There are two kinds of health education I worry about. The first is each person taking better care of themselves - true preventive health care.

While we have made only modest progress here, people are learning. But perhaps the second challenge, that of

educating health professionals about seniors health needs - and how best to help - is an even larger problem.

Training and sensitizing doctors and nurses can have a remarkable result. As recently reported, the simple act of careful pre-operative patient consultation has proven to reduce hospital stays by an average of two and a half days.

But as one measure of where we are with seniors, although the nation's 127 medical schools are affiliated with over 400 teaching hospitals, where teaching nursing homes are concerned the total number of affiliations is five.

What should we be most concerned about for the 1980's and beyond in aging policy?

There are many unmet needs and many issues worthy of our concern. But one fact stands unchallenged - unless we learn to stop out-of-control increases in health costs, neither older Americans nor the federal government itself will have the resources to address any other problem. Unless we bring Medicare costs back into line with economic reality, Americans over 65 aren't going to enjoy retirement secure from the threat of financial impoverishment. Unless we bring health costs under control, Americans over 65 aren't going to share in any rise in our national standard of living. And unless we get our health financing programs back on a budget, we aren't going to be able to think about benefit expansions to cover catastrophic expenses and long term care services that are so important and so necessary.

My message today is as simple as it is sobering. Out of control health costs today constitute a clear and present danger to older Americans -- not only in terms of access to adequate health care, but also to their economic security, their independence, and their individual dignity. It is this issue that must be the principal focus of our concerns, and it's what I want to discuss with you this morning.

Older Americans, today, pay out-of-pocket for health care expenses an average of over $1500 per person a year - that's an unacceptably high financial burden for many older families with fixed incomes - and these out-of-pocket costs have been increasing at more than double the annual rate of inflation for the past decade. Government, too, is finding Medicare and Medicaid to be the fastest growing elements of the budget, again rising two to three times as fast as inflation. These increases, this hyperinflation of health costs, eat up resources that should be available for other essential social services, and contribute to the deficits that now threaten to saddle our children and grandchildren with crushing debt. Medicare Part A - the Hospital Insurance Trust Fund - is projected to become insolvent as early as 1990 and to ring up a cumulative deficit of between $100 and $300 billion by 1995, even with passage of the new DRG prospective payment system last year. We'll have a better idea of just how bad the situation is next Monday, when the social security trustees release this year's report on the status of the trust funds. I might add that this

report will not call attention to how restraints on Medicare alone will almost inevitably lead to a two class system of health care.

Now I've heard, as I'm sure you have, that what we really need today is for seniors to flex their political muscle and write their Congressman demanding that he or she fix Medicare fast, and they better do it without cutting benefits or without raising taxes. Well, I'm never one to discourage anyone from writing to me or anyone else in Congress. But it seems to me that if all we do is write "save Medicare" letters, Medicare won't be saved.

For a truly effective campaign to save the program, we will need a more sophisticated and more demanding program for reform. In my view, the case for a workable program for reform can't be made on the basis of slogans, and it can't be made simply in terms of the "right" to health care for all Americans. What the debate will be over are specific proposals that incorporate different strategies to achieve that goal.

Traditionally, we've had only two choices, two radically different philosophies, two contrasting strategies to control health costs. We can call one the "competitive" model and the other the "regulatory" model.

I have for several years supported the so called competitive model of health care reform, because I believe that it promotes flexibility, innovation, and individual choice - and that it promotes more sensible and affordable alternatives to traditional fee-for-service health care arrangements. Examples of this competitive approach include the Health Incentives Reform Act, which Senator Durenburger and I introduced in 1979, and my bills - now law - to make group practice HMO's and other prepaid health plans eligible for Medicare reimbursement, and to cover hospice services under Medicare.

I remain convinced that this approach promotes innovation, creativity, and the proper use of new technology in our health delivery system. Properly structured, competitive approaches also focus attention on the desires and needs of individual health consumers. But I also have to admit that this strategy for health care reform has been moving slowly. A clear consensus on specifics is still lacking. And most important of all, even if we could agree on what changes to make today, competition strategies are simply not going to be able to relieve the burden of rising health costs anytime soon enough, or produce cost savings anywhere near large enough to rescue Medicare.

But if competition won't work, what about regulation? We are going to need a strategy that is capable of achieving very fast results, and direct regulation can certainly yield quick savings. States that have mandatory hospital rate-setting for all insurance payors report that they can slow down hospital cost inflation. These programs can both lower hospital cost increases and prohibit the kind of cost-shifting that we're likely to see elsewhere, as Medicare DRG

rates are ratcheted down. Given the urgent need for savings, Congress may find irresistable the allure of national all-payor rate regulation. So I'm not surprised that the new health insurance bill sponsored by my friend Senator Ted Kennedy adopts this strategy. In effect, this bill, the Kennedy/Gephardt Medicare Solvency Bill, would impose federal regulation on all states except those already implementing their own all-payor programs. And given the political difficulty of developing their own plans, many state legislators may prefer to leave this regulatory chore to those of us in Washington.

In my judgment, however, the risks of a federal regulatory approach are very great. Imposing a uniform system of controls from Washington on all hospitals and doctors will inhibit change. It will become increasingly restrictive, bureaucratic and inflexible as rates are reduced. This approach would ignore the fundamental regional and other differences in the structure and traditions of health care. Such a system would, I fear, also freeze into place all the shortcomings and misplaced priorities of the current system.

Furthermore, neither of these models lower the already high costs to beneficiaries, and most versions of the competitive model actually increase cost sharing. But, if the status quo, the competition model, and the Washington based regulatory model all extract a price too high for us to pay, how do we achieve Medicare system reform?

As Chairman of the Senate Special Committee on Aging, I have given a lot of thought to how we might restore solvency, promote needed flexibility and innovation, and at the same time protect older Americans from excess out-of-pocket costs.

Not surprisingly, perhaps -- given what I've said so far -- I've concluded that we need a third option. If competition can't work fast enough, and top-down federal regulation is too rigid, then we need another choice.

The third option that I propose is an INCENTIVE approach that would get the results while avoiding the pitfalls of both the competitive and regulatory models. The key to my proposal is a federal/state partnership that taps the creativity and energy of government close to the people. Essentially, this third strategy for health reform is based upon incentives to states to design and implement their own reforms - whether competitive, regulatory, or some combination of both. Federal regulation would be minimal -- states would only be asked to keep health costs below projected Medicare target levels.

The fact is that there is no single, national answer to the health care cost problem. That's precisely why we should permit maximum flexibility to states to implement their own innovative programs. With Medicare insolvency expected in only a few years, we must begin, now, to focus the debate in Congress and to provide leadership based on

new ideas to guide public opinion toward a realistic solution.

That's why, in just a few weeks, I will introduce a comprehensive Medicare reform package. My bill, entitled the Medicare Incentives Reform Act - MIRA for short - will have four major goals. It will hold down health cost increases for all Americans. It will restore solvency to the Medicare HI Trust Fund. It will plug the gaps in existing insurance coverage for Medicare beneficiaries. And it will extend a new protection to older Americans from the catastrophic health costs that can jeopardize their economic security. And we will more than offset the cost of these needed improvements by increasing the excise tax on the largest single cause of these catastrophic costs, namely cigarettes.

First and foremost, my legislation will grant financial rewards to those states with cost containment programs that limit hospital expenditures for all insurance payors. States that take this initiative will receive a higher Medicare payment for hospitals and an increase in the federal match for the Medicaid program. States that do not develop comprehensive cost control programs would be required to comply with Medicare's present DRG prospective payment system. Payments to hospitals under this system would be extremely tight; my bill will hold annual increases in the rate for each DRG to the market basket index only. In addition, it will penalize hospitals who attempt to "churn" the DRG system by reducing payments for excess hospital admissions to 50% of the normal DRG payment rate.

Second, my legislation will address the spiraling increases in Part B of the Medicare program. The bill would discard the "reasonable charge" method of paying physicians that has distorted health care delivery by encouraging unnecessary testing, unnecessary surgery, and unnecessary hospitalization. New and more fairly balanced fee schedules would, by contrast, encourage preventive and diagnostic care in the doctor's office.

In addition, physicians would be required to accept assignment under Medicare for all inpatient services. For those services performed outside of a hospital, the bill would establish several incentives for physicians to accept Medicare rates as payment in full -- from streamlined billing and public directories of doctors who accept assignment to interim fee freezes for those who do not.

These measures, together with some other modest changes, will save enough to ensure Medicare's financial health through the next decade.

Third, medical insurance coverage for all Medicare beneficiaries would be dramatically improved under my plan. For the first time, Medicare would protect elderly Americans from catastrophic health care costs by providing coverage for an unlimited number of hospital days and by eliminating all co-payments for both hospital and physician care. Further financial protection will come from the elimination

of physician "extra billing" for inpatient services. Additionally, total Medicare deductibles would be limited to $400 annually. This restructuring will dramatically simplify Medicare while eliminating the need for anyone to purchase costly Medigap supplemental insurance. And part of these costs, and to complete the financing package, will be underwritten by doubling the federal cigarette tax.

Furthermore, should it prove necessary, I am prepared to incorporate an income-related premium for Part B.

Beyond restoring Medicare's solvency, let me summarize, from another perspective, what the changes I've described to do.

Medicare was originally proposed not just as a health program, but, most importantly as an essential means of stabilizing the incomes of social security beneficiaries - in other words, Medicare was to insure income stability.

Today its ability to in that sense insure has been overtaken by dramatic changes, extrodinary medical advances and equally extraordinary costs.

By stressing the necessary descipline of an upfront but affordable deductible, and by eliminating not only all copays but all annual limits on acute care, we have returned medicare to its original purpose of truly sheltering the elderly against health cost threats to their income security.

This is a comprehensive and complicated proposal; it merits further thought and deliberation. But I wanted to share its basic outline with you today. If you agree that the bill I have outlined deals effectively and fairly with the major challenges that face us in Medicare, I ask for your full support. I also would welcome your comments and further suggestions. Most of all, I urge you to dedicate yourself to help create a political consensus necessary to ensure action.

The kind of opposition that proposals like mine will generate will be well-financed and persuasive. We can count on the tobacco lobby to oppose any increase in cigarette excise taxes, despite recent studies showing the health costs for heavy smokers add up to over three dollars for every pack smoked. We can count on those in the health care professions -- those with a vested interest in the status quo -- to oppose us also. There is always resistance to necessary change, especially when the proposed changes may affect the paycheck, and I've noticed that the bigger the paycheck, the greater the resistance.

This kind of opposition can't be beaten with just the resources of the aging community alone. We're going to need allies in this fight to strengthen our forces. It seems to me that both business and labor share our commitment to control health costs. After all, they pay or bargain for three out of every five health care dollars. And they make an investment in Medicare with every payroll and paycheck.

They should and must be included in a coalition for health reform and Medicare solvency. Together, we can do the job.

So I leave you with a priority, a proposal, and a charge. The priority for our actions in the coming years must be health reform, for the sake of seniors' health costs, for the sake of Medicare solvency, and for the sake of affordable health care for all Americans. I urge you to become involved as advocates for health reform and I ask your support for my proposal. And finally, I believe we must prepare ourselves for the coming fight by reaching out not only to seniors themselves, but also to business, labor and others who share our concerns and our values. To prevail, we must prepare for a tough and sustained fight. And prevail we must, for nothing less than the economic and health security of present and future generations of older Americans is at stake.