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CONGRESS, PUBLIC POLICY, AND THE FUTURE: A CONVERSATION WITH BILL GRADISON

by John K. Iglehart

Prologue: Bill Gradison is a Legislator to whom colleagues turn when, faced with a vote on an issue on which they lack adequate knowledge, they need instant advice on how to cast their ballot. Thus his influence on important economic issues in recent years has grown far beyond one vote. Gradison has emerged on the House Ways and Means Committee as the most influential Republican on health financing issues. Educated at Yule University and the Harvard Business School, Gradison has served in the House since 1974. A former investment broker, he was a member of the Cincinnati City Council for thirteen years and also its mayor in 1971. His basic approach to legislating has been to ask basic questions about programs and seek long-range solutions that make sense. But his instincts in this regard have been deflected by the firefighting approach to policy making that Congress has adopted since the budget process begun dominating events on Capitol Hill. Gradison has been a voice of moderation on the House Ways and Means and Budget Committees. While he is not a close ally of the chairman of the House Ways and Means Subcommittee on Health, Fortney H. (Pete) Stark, Gradison has been influential in focusing Stark on issues that need addressing. Generally speaking, Gradison favors a more assertive federal government on important issues like medical care for the uninsured than does the Reagan administration. Like many Democrats and some fellow Republicans, Gradison has been troubled at the lack of cooperation and dialogue that has developed between Congress and the Department of Health and Human Services on a wide range of issues. Without easy access to the information and policy analysis resources of the executive branch, Republicans like Gradison have been forced to rely more heavily on their own instincts and on cooperation with Democrats to develop compromise solutions that can deliver a majority on the House floor.
Q: Congressman Gradison, what are the major forces driving federal health policy making today?
A: I would say the three most important considerations are cost cutting, cost cutting, and cost cutting. The entire process of setting health policy is being affected and distorted by the overriding emphasis on moderating government spending. This emphasis rings true not only in budgeting but also in taxation issues that impact health care, such as the deductibility of employer-paid health insurance premiums and the treatment of tax-exempt bonds issued by nonprofit hospitals. There are some legislators, and I count myself in this group, who believe we must raise our voices louder than usual on behalf of long-term health policy rather than remain preoccupied with shorter term policy goals which turn on budget reductions.

Q: There seem to be fewer legislative voices than a decade ago who are willing to commit their time and invest their political energies in health and medical care issues. Why does that seem to be the case?
A: There are fewer legislators seriously involved in health issues, for a variety of reasons. Certainly one of the primary reasons is that, in federal policy terms, health care has become largely a take-away area, given the looming deficits. There is very little talk today of expanding in any major way health benefits under federal programs. The emphasis is on trying to restructure or maintain what’s already on the books. I would also say that there has been a splintering of responsibility within the Congress on health issues, which makes it more difficult for individual voices to be heard. In particular, on the House side, the split in legislative jurisdiction that took place in 1975 between Medicare and Medicaid has complicated the policy process. And perhaps, even more important, is the growth in influence of the congressional budget committees.

Q: The Reagan administration has certainly led the field when it comes to health cost cutting—the overriding pressure driving policy. What is your general view of administration health policy? Do you despair of it, support some or most elements of it, where do you come down us a Republican?
A: I believe that beneath the surface of this emphasis on short-term cost savings is a sense of direction towards a more competitive, market-oriented approach to the purchase of health care by the federal government. As a result, we have been moving ahead in some specific ways towards greater use of the voucher approach in Medicare, for example, by authorizing the Health Care Financing Administration (HCFA) to contract with health maintenance organizations (HMOs) and competitive medical plans (CMPS). The administration now is thinking about expanding the number of organizations that could sign up Medicare beneficiaries on a capitated basis, that is to say, under a fixed payment arrangement that places the provider of care at financial risk for delivering care to enrolled elderly people.
Evaluating Medicare’s Prospective Payment System

Q: You have been involved with the structuring and enactment of Medicare’s new hospital payment mechanism, a prospective system based on 467 diagnosis-related groupings (DRGs). At this juncture, what is your opinion about how this payment approach is working?
A: I would say that, initially, the push towards DRGs derived as much from a belief that Medicare’s financial relationship to hospitals needed restructuring as it did from a need to save money. I don’t quarrel significantly with what has been done along the lines of restructuring. My concern is that if, over a period of years, year after year, Congress acts to freeze the amount of money allocated for Medicare’s hospital expenses, then prospective payment could badly distort the whole process. Carried to an extreme, Medicare would run the risk of reducing the quality of medical care for its beneficiaries.

Q: But certainly a DRG-based payment system does not represent the ideal policy endpoint in your thinking. For at least five years you have been one of the staunchest advocates on Capitol Hill for a market-based medical care system. How does your advocacy on behalf of price competition square with Medicare’s current regulated arrangement?
A: I view the present system as neither fish nor fowl. DRGs are a form of price fixing as I see them, and while they do provide a greater economic incentive than did retrospective, cost-based reimbursement for efficiency, I don’t view DRGs as a viable long-term solution. It seems to me there is a serious risk, quite apart from any theoretical considerations or philosophical biases, that the DRGs may in time break down because of the difficulty of calibrating them with sufficient accuracy to assure that an efficient institution can remain viable if it is heavily dependent on DRG reimbursements. Or to be more direct about it, I am not sure we are smart enough to write a formula that will deal fairly with many thousands of different hospitals across the country.

Q: Given these difficulties with DRGs, do you anticipate that Congress will change Medicare’s hospital payment methods in a significant way anytime soon?
A: It is unlikely that Congress will alter the DRG mechanism in any major way in the near future. I think the movement to a national rate is inexorable and irreversible.

Q: Do you support the movement to urban and rural national rates that would apply to all hospitals subject to Medicare’s prospective payment system?
A: Yes, I do. I believe we must give DRGs a full test. And I think we ought to pay particular attention to the recalibration of DRGs in an effort to deal with some of the identified issues—disproportionate share, intensity, graduate medical education, the rural/urban payment split, and wage rates. Right now, I think the information on the impact of prospec-
tive payment is anecdotal at best. And anecdotal information is unlikely to change public policy. Furthermore, I do not think that a finding that patients are being released quicker and sicker—if that were a finding of a comprehensive study—necessarily answers the question, because if those folks are moved to an appropriate, lower cost setting in a skilled nursing facility or at home, that’s great. The system was designed to encourage that kind of action. Therefore, I think we have got to focus on ultimate health outcomes, which are harder to determine, than the condition of people when they are discharged from the hospital. So we need some rather sophisticated measurements which, unfortunately, are not really available today. Politically, I think the real crunch for the future of DRGs will come, if it is to come, when hospitals start to fail and questions are raised over whether DRGs had something to do with that. I don’t see any signs of that happening anytime soon.

Q: It is my impression that very few members of Congress recognize, even today, the massive redistribution of federal dollars that will occur as Medicare’s hospital payment rates become national rates. As you well know, whenever there are suggestions of a redistribution of the federal largesse—be it in energy, transportation, welfare, or health—that usually sets off a hue and cry on Capitol Hill like few other issues. Why is it that in the instance of prospective payment, this has not occurred?

A: It came close to occurring on the issue of whether to change Medicare’s hospital payment rate formula from the 50 percent federal DRG portion and 50 percent hospital specific portion to 75-25. Clearly, states were choosing up sides and initially it appeared to be having some influence, but ultimately the effort died. There were legislators from states where hospitals would lose Medicare funds that didn’t back the financial interest of these institutions. I am not sure of the reason why. One possible explanation is that there is no hard evidence that the losing hospitals are hurting today. The recent financial data reported by the American Hospital Association showed that most hospitals had very good years. Not every hospital, but the majority of them. And members are aware of that. Another possible explanation is that because Medicare’s hospital payments flow from a fixed sum of dollars, legislators recognize it has become a zero-sum game. So in order to pay some hospitals more, we would have to pay others less. There is no question that this redistribution will ultimately cause disquiet, but if Congress had been satisfied with the status quo, it would never have enacted DRGs.

Q: Are Ohio hospitals winners or losers under Medicare’s prospective payment scheme?

A: Many Ohio hospitals would lose Medicare dollars in the shift to national rates. Keep in mind, though, that not all hospitals in any given state are losers; we’re talking here about the preponderance of hospitals.

Q: Are you an advocate of extending the DRG-based payment concept under
Medicare to physician services, home health care, and skilled nursing care facilities?

A: Yes, I am an advocate of moving in that direction, assuming that Congress can find sensible ways to do it. Regarding physician services, it appears to me that extending the DRG concept to surgical procedures would be worth a try. It isn't as clear to me how it would work with medical services, where the variation in treatment and the cost of care is much greater than it is in the surgical realm. I also would want to make certain that any policy steps we adopt along these lines do not preclude or make more difficult later moves toward a capitation system in the future. I don’t want to end up in a policy cul de sac that would make it difficult to move back into the main stream. In my view, the main stream is a system that pays providers on a capitated basis.

Q: Medicare has been testing the utility of enrolling beneficiaries in capitated health plans for several years. I take it that, given your strong advocacy of moving more forcefully in this direction, that you regarded these demonstration projects as successful.

A: Yes, on the whole, I believe these demonstrations were successful. They showed that the Health Care Financing Administration (HCFA) could contract for Medicare services with HMOs and know, predictably, what the cost would be to the federal government. And that cost was less than fee-for-service medical care. HCFA and the participating HMOs also learned that some Medicare beneficiaries were prepared to enroll in closed-panel plans, changing doctors in the process, if the change meant more predictability in the out-of-pocket cost and a richer benefit package. But some plans had trouble, too. We had a notable failure in Cincinnati, probably the biggest one in the country. A large HMO, organized as an independent practice association and sponsored by our Academy of Medicine, enrolled about 10,000 Medicare beneficiaries. But the plan found that it was losing money at a rate of about $650,000 a month, or more than $6 million a year, and decided to withdraw. One current problem I have, and this is really a minor, picky thing, is the administration’s tentative decision to set up separate peer review mechanisms for HMOs and CMPs rather than depend on the already established national network of peer review organizations (PROS). PROS should be charged with looking for instances of underutilization of services as well as overutilization. Looking at the activities of HMOs would help to promote among PROS a more balanced approach in assuring the quality of care financed by Medicare. Another relatively minor item that I would like to see changed is the requirement that all capitated plans, which contract with HCFA to serve Medicare beneficiaries, must have at least 50 percent non-Medicare enrollees. I believe that is a dreadfully strict requirement that will stifle the development of new plans.
Envisioning Health Care's Future

Q: You have cited several central tenets of your thinking. What are the other central themes you are pursuing or, put another way, what is the vision of health care in the future as Bill Gradison sees it?
A: It would include a price-oriented system of purchasing health care by those who really pay the bill—private businesses and federal, state, and local governments. And it would, to make sense, fill the coverage gaps which would inevitably arise under a market model. Also, this approach would require far more explicit financing of care for the poor who are uninsured and of graduate medical training, items that have until recently been buried in the patient care revenue stream. I find troublesome the administration’s failure to recognize, or at least support, the need to finance these items on an explicit basis under a market approach. Without explicit financing of the items that Congress and the public have clearly identified as socially useful and worthy of government assistance, support for a market model would eventually break down.

Q: But at this point, it seems that the administration is far from alone in its unwillingness to maintain support for indigent care or graduate medical education through Medicare. Many congressional Democrats are prepared to scuttle the cross-subsidies that pay for these items.
A: Well, that’s right. I would have to say that right now, and, in my opinion, for the foreseeable future, the federal policy, if there is a policy, is one of benign neglect. We know there are some problems out there—uncompensated care, for example, but basically the federal government is staying out of that realm and leaving it to states to work out. Such activity at the state level is not unhealthy, but we need a franker recognition at high national policy levels that something needs to be done about gaps in coverage and access.

Q: You did not mention in your future vision of health care whether you would maintain the current tax exemption for employer-paid health insurance premiums. Do you remain in support of removing this exemption?
A: Well, if it were totally up to me, I would place a ceiling on the exemption. My objective is simply to make the ultimate consumer of health care more conscious of its cost and, therefore, a more prudent purchaser. I think there is enough evidence to indicate that doing so—as long as the poor are protected—can substantially reduce the cost of care without impacting adversely on beneficiary access to it or the quality of the care.

Q: Professor Alain Enthoven of the Stanford Graduate School of Business has proposed replacing the tax exemption with a refundable tax credit, the goal of which would be to distribute this form of encouraging people to purchase health insurance on a more equitable basis across economic groups. Would you support a proposal like that?
A: I have not studied Professor Enthoven’s proposal carefully, but there is no question that there are major gaps at the low-income end caused in part by the tax structure. The tax exemption for employer-paid health insurance premiums is regressive in that it rewards people of middle and high incomes and does little or nothing for people without means. This is simply unfair.

Long-Term Care And The Hospice Benefit

Q: You have devoted considerable time to the subject of long-term care and were instrumental in winning congressional enactment of the hospice benefit under Medicare. What is your view of these issues generally, is there any prospect that Congress will address them seriously in the future?
A: The federal government is very unlikely to take on new costs anytime soon to provide long-term care, but I do believe that it would be appropriate to experiment during this period. I am particularly looking forward to the results of research demonstrations already underway, such as the social HMOs that are operating at four sites and some of the tentative efforts by private insurance companies that are tiptoeing into this field. It’s already quite clear that this issue will be extremely difficult to address. There simply are no easy, low-cost answers. The questions seem to be, should government extend through some social scheme benefits similar to Medicaid’s long-term care to a broader segment of the population, what would it cost, and what private efforts would we offset in the process?

Q: How about Medicare’s hospice provision. Have you been satisfied with HCFA’s implementation of this provision?
A: I have had some concerns over the implementation of the hospice Medicare benefit by HCFA, HHS (Department of Health and Human Services), and OMB (Office of Management and Budget). A number of my initial concerns were addressed, though, by the time the final implementing regulations were issued in December 1983. One of my initial and continuing concerns, however, involves the levels of payment the hospices are to receive for caring for terminally ill Medicare patients. The administration based its reimbursement rates on preliminary data from the National Hospice Demonstration Study. Although the results of the study were required by statute to be submitted to Congress by September 1983, the final report has yet to be released by HCFA. The withholding of the data used to set the rates and the cost experience of hospices now providing care under the actual benefit suggest that the administration’s rates were set unrealistically low. A major concern that I have encountered is the small number of hospices that have qualified to participate under the Medicare hospice option or are in the process of seeking qualification. There are some 1,200 operating hospices in the United
States and only about 230 of these facilities have qualified or are somewhere in the certification pipeline. The relatively few now certified does not bother me much at this early stage although, of course, the more hospices that are certified, the more widely available the option will be to Medicare beneficiaries. Representative Leon Panetta and I introduced legislation this year that would remove the benefit’s sunset date of Oct. 1, 1986, since the sunset, itself, is a disincentive for hospices not currently certified to go through the process. I have, however, believed since the beginning that we should have a tight definition of a hospice so as to give the program a chance to operate on that basis for a time before opening up the doors. The flip side of that and the second objection we have encountered is the core services requirement. This aspect of the program limits the number of eligible hospices. So far as I have been able to determine, the costs of the program have not been out of line. In fact, the Congressional Budget Office advised me that by eliminating the sunset provision and thereby extending the hospice benefit, there would be a three-year savings to the entire Medicare program of around $17 million. Thus the fears of the OMB, which led the agency to oppose enactment of the Medicare hospice benefit, were not realized. I suspect that a part of the reason costs have remained relatively low is that the average length-of-stay of a Medicare patient under the benefit is much shorter than anticipated. This, I suspect, derives from a reluctance of patients and their families to acknowledge that the illnesses are terminal and thus, that hospice may be the most appropriate setting for the patient.

**Health Care As Business**

Q: As the health care system evolves into a more commercial and entrepreneurial mode, what effect do you anticipate this trend will have on Congress, in terms of the likelihood that legislators will view hospitals as less like community institutions and more like businesses, and will view physicians more like small businessmen than as professionals rendering a medical service?

A: I don’t think that this trend has had an impact on the thinking of most legislators yet. My perception is that legislators have viewed certain segments of the health care industry, if you will pardon the expression, as being proprietary for a long time. For example, pharmaceutical companies, most nursing homes, and physicians, to the best of my knowledge, do not take the vows of poverty and do operate on a for-profit basis. The big structural change seems to have occurred in hospitals. But I believe that most members, even those from areas in the South and Southwest where there has been relatively rapid expansion of proprietary institutions, still have a mind-set that hospitals are generally pro bono community-based institutions, largely nonprofit, and should be viewed in a different way than the profit-making segments of the health care industry.
Q: The House Ways and Means Committee, of which you are a senior member, has begun the difficult process of rewriting the tax code. In its search for simplification, what are the principal attitudes on the committee relating the tax structure to health care?
A: It’s a little early to know. The Reagan administration has proposed to limit the issuance of tax-exempt bonds by hospitals under a state-by-state cap based upon so many dollars of bond issue per year, and let the state determine how much of that should go for waste treatment, hospitals, or certain other purposes. Housing is in there, too, but it’s given a protective category.
Q: That sounds like planning to me. I thought the administration was opposed to planning.
A: Well, that’s one of the drawbacks of it. For those of us who are not enamoured of certificate of need laws, it almost requires their creation just from the point of view of deciding who would be eligible to issue bonds in any given year. I think it’s another example of tax policy being driven without a recognition of the health-related implications. This provision was put together in relation to the use of tax-exempt bonds for nontraditional purposes of housing or industrial development, not for streets, sewers, and schools. Health is not alone in this regard. I hear many interests complain that the administration’s bill does not adequately address, say, international trade or industrial modernization or retirement income. So health care is not alone regarding the way it is treated in the tax bill.
Q: Thank you.