

**ADMINISTRATION'S PRINCIPLES TO STRENGTHEN  
AND MODERNIZE MEDICARE**

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**HEARING**

BEFORE THE

**COMMITTEE ON WAYS AND MEANS**

**HOUSE OF REPRESENTATIVES  
ONE HUNDRED SEVENTH CONGRESS**

FIRST SESSION

—————  
JULY 19, 2001  
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**Serial No. 107-39**

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**ADMINISTRATION'S PRINCIPLES TO  
STRENGTHEN AND MODERNIZE MEDICARE**

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**THURSDAY, JULY 19, 2001**

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON WAYS AND MEANS  
*Washington, DC.*

The Committee met, pursuant to notice, at 10:30 a.m., in room 1100 Longworth House Office Building, Hon. Bill Thomas (Chairman of the Committee) presiding.

[The advisory announcing the hearing follows:]

# ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE,  
July 12, 2001  
FC-9

CONTACT: (202) 225-1721

## **Thomas Announces a Hearing on the Administration's Principles to Strengthen and Modernize Medicare**

Congressman Bill Thomas (R-CA), Chairman, Committee on Ways and Means, today announced that the Committee will hold a hearing on the Administration's Principles to Strengthen and Modernize Medicare. **The hearing will take place on Thursday, July 19, 2001, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

Oral testimony at this hearing will be from invited witnesses only. The witness will be the Honorable Tommy Thompson, Secretary of the U.S. Department of Health and Human Services. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

### **BACKGROUND:**

On July 12, 2001, President George W. Bush unveiled a set of principles to guide Congress in its work to strengthen and improve Medicare, while adding a prescription drug benefit to the program. The hearing will examine the Administration's Medicare modernization principles in greater detail.

In announcing the hearing, Chairman Thomas stated: "The President has shown courage in tackling the challenges of this complex and vital program. His leadership will provide momentum in developing bipartisan solutions to Medicare's growing shortfall, and help modernize the aging Medicare program with the inclusion of 21st century prescription drug and preventative care benefits."

### **FOCUS OF THE HEARING:**

Over the past several months, the Health Subcommittee has held a series of hearings on various aspects of the Medicare program in need of improvement. In those hearings, the Subcommittee has examined the need to add a prescription drug benefit to Medicare, challenges to long-term program solvency, opportunities to modernize the fee-for-service benefit package, ways to enhance private-sector options for beneficiaries, and regulatory barriers confronting providers.

The full Committee hearing will give the Administration an opportunity to present its recommendations for solving the challenges facing the Medicare program.

### **DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:**

Any person or organization wishing to submit a written statement for the printed record of the hearing should *submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, with their name, address, and hearing date noted on a label*, by the close of business, Thursday, August 2, 2001, to Allison Giles, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their state-

ments distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Committee, room 1102 Longworth House Office Building, by close of business the day before the hearing.

#### **FORMATTING REQUIREMENTS:**

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, typed in single space and may not exceed a total of 10 pages including attachments. **Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.**

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press, and the public during the course of a public hearing may be submitted in other forms.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman THOMAS. If our guests can find seats, please, and our Members.

Thirty-six years after its inception, the Medicare Program is woven into the fabric of lives of almost 40 million American seniors and people with long-term disabilities. They have placed their trust in Congress and the administration to ensure a system of accessible and affordable health care that continues to address their needs.

Medicare stands under a lengthening shadow of rising costs and antiquated processes. The problems confronting it are real. If we do not act now, combined Medicare spending will quadruple as a percentage of the economy by 2075. Most of us will not be here at that time, but we have children and grandchildren who will be counting on Medicare.

Modern technology offers the prospect of a longer and richer life through phenomenal advances, primarily in prescription drugs. Almost 400 new drugs have been developed in the past 10 years. Access to these drugs must form a fundamental part of the structure of Medicare. I say must form a fundamental part of the structure

of Medicare because it does not today. This has to be achieved in a way that protects the program's long-term financial viability while making it more responsive to beneficiaries and providers that serve our seniors and disabled. Given these responsibilities, simply adding an expensive new outpatient prescription drug benefit to the program cannot be the answer.

President Bush has established a broad and coherent framework for crafting a modern Medicare Program. His principles offer hope and reassurance to seniors and the disabled in critical aspects of their lives. They reflect President Bush's administration's powerful commitment to quality health care.

I am delighted to once again welcome Secretary Tommy Thompson who joins us today to discuss these principles and how we can work together to revitalize the critical program that is before us.

Nine hearings on how best to improve and streamline the vast Medicare Program have been held this year either by the full Committee or the House Subcommittee under the leadership of Chairwoman Nancy Johnson.

Mr. Secretary, you have begun to lay the groundwork. Since we last saw you, you have tackled some key problems at the often criticized and formerly named Health Care Financing Administration (HCFA) with the help of its new administrator, Tom Scully, who I believe joins us here today. I know you will ensure that its successor, the new Centers for Medicare and Medicaid Services, or CMS, gets off to a strong start with a renewed commitment to service and quality of care.

Not every change needed to improve Medicare requires legislation. Under your existing administrative authority you have taken initial steps to strengthen the program and to implement many of the administrative reforms suggested in a bipartisan letter from House Subcommittee Chairwoman Nancy Johnson and its Ranking Member, Pete Stark, which I believe was sent to you in the middle of May. I hope more will be done to fully implement their comprehensive and detailed recommendations.

I know that working together we can coordinate structural improvements that can be achieved administratively, with, of course, more fundamental reforms that will require congressional involvement.

We all know we have a big job ahead of us. Mr. Secretary, I look forward to working with you and with the President and with my colleagues in getting the job done this year.

And with that, I would recognize the Ranking Member, the gentleman from New York, my friend Mr. Rangel.

[The opening statement of Chairman Thomas follows:]

**Opening Statement of the Hon. Bill Thomas, M.C., California, and  
Chairman, Committee on Ways and Means**

Thirty six years after its inception, the Medicare program is woven into the fabric of the lives of almost 40 million American seniors and people with long-term disabilities. They have placed their trust in Congress and the Administration to ensure a system of accessible and affordable health care that continues to address their needs.

Medicare stands under a lengthening shadow of rising costs and antiquated processes. The problems confronting it are real. If we do not act now, combined Medicare spending will quadruple by 2075. Most of us will be dead and gone by then, but we have children and grandchildren who will be counting on Medicare.

Modern technology offers the prospect of a longer and richer life through phenomenal advances in prescription drugs. Almost 400 new drugs have been developed in the past ten years. Access to these drugs must form a fundamental part of the structure of Medicare. But this must be achieved in a way that protects the program's long-term financial viability while making it more responsive to beneficiaries and the providers that serve them.

Given these responsibilities, simply adding an expensive new outpatient prescription drug benefit to the program is not the answer.

President Bush has established a broad and coherent framework for crafting a modern Medicare program. His principles offer hope and reassurance to seniors and the disabled in critical aspects of their lives. They reflect his Administration's powerful commitment to quality health care.

I am delighted to once again welcome Tommy Thompson, Secretary of Health and Human Services, who joins us today to discuss those principles and how we can work together to revitalize this critical program for our nation's seniors and disabled citizens. Nine hearings on how best to improve and streamline the vast Medicare program have been held this year by either Ways and Means or its Health Subcommittee, illustrating the dedication we share with the Administration to providing quality health care to future generations.

Mr. Secretary, you have already begun to lay the groundwork. Since we last saw you, you have tackled some key problems at the often criticized and formerly named Health Care Financing Administration, or HCFA, making Medicare more responsive to its beneficiaries and providers. With the help of its new Administrator, Thomas Scully, who joins you here today, I know you will ensure that its successor, the new Centers for Medicare and Medicaid Services, or CMS, gets off to a strong start, with a renewed commitment to service and quality of care.

Not every change needed to improve Medicare requires legislation. Under your existing administrative authority, you have taken initial steps to strengthen the program and to implement many of the administrative reforms suggested in a bipartisan letter from Health Subcommittee Chairwoman Nancy Johnson and its Ranking Member, Pete Stark, on May 14. I hope more will be done to fully implement their comprehensive and detailed recommendations.

Working together, we can coordinate structural improvements that can be achieved administratively with more fundamental reforms that require Congressional involvement.

We have a big job ahead of us. I look forward to working with you, Mr. Secretary, with the President, and with my colleagues on Ways and Means, to get the job done this year.

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Mr. RANGEL. Thank you, Mr. Chairman, and thank you, Mr. Secretary, for once again coming before us. I want to apologize if you see Members leaving. Unfortunately, the leadership has scheduled a very, very important bill, the charitable choice bill. It's one of the main points that the President has made in his speeches. A large part of that includes tax provisions, and it is embarrassing that we would have you here at the same time that many of us, from time to time, will not only have to go to the floor to vote, but to explain our position on the bill. But as you well know, being a well-seasoned politician, that this is not an affront to you, but the problems that we face in trying to get a legislative schedule on the floor as well as in our Committee.

As relates to the job that is before you, let me be candid. There have been no campaign promises that were made by President Bush, or then-Governor Bush, that I did not support. He amazed me as to how he "out-gored" Gore on the question of reforming Medicare, prescription drugs, patients' bill of rights, and so I just was wondering how we would be working together toward those goals.

Now, so far we have principles, and that is good because the budget being the way it is, you do not have to pay for the prin-

ciples. But sooner or later, we know that it's going to cost. That is where the rubber hits the road, dealing with the details, as the Chairman has pointed out. Of course, as Chairwoman Nancy Johnson and my colleague, Pete Stark, to whom at this time with the Chair's permission, I would like to yield.

Mr. STARK. I thank the Chairman for yielding and join in welcoming Governor Thompson. The President's Medicare principles, Mr. Secretary, remind me of, as they do my Ranking Member, that campaign talking points are not really a genuine effort to lead us to anything productive. An old saw, they are all hat and no cattle. They raise more questions than they answer, and they merely hint at what is to come. And from what I can tell, that is not very pretty for Medicare beneficiaries.

We still don't know if the President has a plan to add prescription drug benefits to Medicare and what the plan would be, unless it's just simply these discount cards, and they leave much to be desired. We still don't know what the President supports in order to fulfill his promises. Is he willing to guarantee benefits at least as good as those offered today to current beneficiaries for the foreseeable future? Is he willing to show the same commitment to America's Medicare beneficiaries as he has shown to wealthy Americans who benefited from the recent tax cuts?

The only policies he has unveiled is this drug discount card program; as I call it, the Buck Rogers Rocket Ranger discount plan. And if these cards were the answer we wouldn't have the current outcry for real Medicare coverage that we have today. The little bit of research that is out there shows that these cards often provide little or no discount.

I had a letter from the Kansas insurance commissioner that I would like to insert in the record. I won't read the letter, but she states her concerns with the discount programs that operate in Kansas. Quoting her, she says, the most common complaint is that while the literature touts the discounts upwardly of 40 to 60 percent, the discount is considerably less, often less than 10 percent, and closes her letter with the adage that what sounds too good to be true remains too good to be true.

The Bush discount card is a placebo, at best. And I guess I have to warn you, Mr. Secretary, today I am petitioning the court to intervene as a plaintiff in the lawsuit filed by the National Association of Chain Drugstores and the National Community Pharmacists Association against yourself and Mr. Scully. The lawsuit contends, and I agree, that the program is illegal. It was created in secret and did not consult with the Congress, as all too often does not happen, at least with the Democrats. We are never advised of what is going on in the Medicare issue, and that is no way to begin bipartisanship.

And I'm sorry that—I promise if we take your deposition, I won't do it during muskie season, unless you would like to do it up in northern Wisconsin when they are biting and I will come there to take your deposition. But I look forward to your other testimony and our discussion today, and thank you for being with us.

Secretary THOMPSON. Thank you.

Chairman THOMAS. Well, Mr. Secretary, with those opening remarks, welcome to the Committee once again. Any written state-

ment you have will be made a part of the record, and we invite you to address the Committee in terms of the concerns you have in front of you, in any way you see fit. And with that, welcome.

[The opening statement of Mr. Ramstad follows:]

**Opening Statement of the Hon. Jim Ramstad, M.C., Minnesota**

Mr. Chairman, thank you for holding this important hearing on the Administration's principles for strengthening and modernizing Medicare.

The eight principles outlined by the Administration provide an excellent framework for common-sense and compassionate improvements to the Medicare system.

Representing a state penalized by the unfair and unjust Medicare managed care reimbursement formula, I know firsthand the difficulties that seniors face when irrational federal government decisions deny them the choices they deserve.

And as one who represents an area with literally hundreds of medical technology companies, I also know firsthand the damage to small businesses, their employees and seniors when the federal system irrationally delays or denies coverage of their innovative products. I understand the dilemma facing seniors when they are denied life-saving and life-improving technology, and I've authored legislation to ensure that seniors have access through Medicare to crucial new technologies.

That's why I'm so encouraged by the Administration's leadership on making Medicare make sense and better serve our nation's seniors.

I am grateful to Secretary Thompson for appearing today to lay out the Administration's principles, and I look forward to working with him and my colleagues to bring this 1965-era program into the 21st Century.

Thank you, Mr. Chairman.

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**STATEMENT OF HON. TOMMY G. THOMPSON, SECRETARY, U.S.  
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Secretary THOMPSON. Thank you very much, Chairman Thomas.

Chairman THOMAS. Mr. Secretary, I will tell you that these microphones are very unidirectional, and so if you will get fairly close to it and talk directly into it. We are going to change the sound system soon.

Secretary THOMPSON. Thank you. Thank you, Chairman Thomas, Congressman Rangel, Congressman Stark, and Chairperson—Chairwoman Nancy Johnson, and all the other members of this Committee. Thank you for this opportunity to testify before you today.

I am very pleased to be here to discuss President Bush's framework for modernizing and improving the Medicare Program and to talk to you about some very exciting initiatives now underway.

Medicare has provided health care security for millions of Americans for more than 35 years, yet Medicare's benefit package has often remained rooted in the 1960s. For example, outpatient prescription drugs, an increasingly essential part of effective health care, are not included in the package. Coverage for preventive services have lagged behind developments in private insurance plans. Medicare's current cost-sharing structure does not include protections for the sickest beneficiaries with the highest medical costs. Put simply, it is past time to modernize and improve the Medicare system.

That is why the President has worked so hard with Members of Congress from both parties to develop a framework to guide legislative reform efforts to strengthen and improve the Medicare program and to keep the Medicare benefit secure. Since I last testified before this Committee, I have moved my office to the Centers for

Medicare and Medicaid Services, or CMS, what was formerly called HCFA, Health Care Financing Administration. I spent a week out in Baltimore, learning and listening and developing initiatives. I met many dedicated professionals. But I also found a system that needs fundamental changes in it to provide the health care that seniors and disabled citizens need and which Congress expects us to do.

The President passionately shares that view. Last week it was my privilege to join him as he described the principles that he believes should underlie any effective modernization effort. We want to improve Medicare at every level, both in the functioning of its programs and the quality of its benefits. But there are many things that can be done now, even before we tackle the larger issue of comprehensive modernization of the system. President Bush and I are moving forward with significant changes that will help ensure that Medicare better serves seniors, both today and in the future.

First we appointed Tom Scully and Reuben King Shaw to be the number one and number two people at CMS. First, we are advancing constructive regulatory relief to enable physicians, nurses and other care givers to spend more time with patients, which has always been a criticism that they spend too much time on paperwork. As you know, I am taking aggressive steps to bring a culture of responsiveness to the whole Department of Health and Human Services (HHS). Nowhere is this culture more needed than at CMS, which I heard from all of you; from both political parties. This is the Department's largest agency and was the problem child. But it also provides health benefits to more than 70 million Americans.

And to get the ball rolling, I have instructed CMS to hold listening sessions out in the field, just like each of you holds town-hall type meetings to better understand what your constituents are thinking. CMS officials need to hear from the people affected by their programs, including seniors, Medicaid recipients, the disabled, the physicians and health care providers.

We are also creating seven private sector health insurance working groups to suggest improvements to the way that CMS interacts with physicians, health care providers and beneficiaries.

We are also forming a group of in-house experts from the wide array of Medicare program areas within HHS. I am asking them to think innovatively about how we can reduce administrative burdens and simplify our rules and regulations. We are already taking some major steps, but CMS will eliminate unnecessary data that has been demanded of hospitals and skilled nursing facilities in their Medicare cost reports. We are going to eliminate those report requirements as soon as we can after September 30th, 2001, when they expire in the law. This is going to shrink the cost reporting by about 10 percent, something that hospitals have written to each of you complaining about.

We are also doing away with redundant questionnaires and getting rid of time-consuming cost calculations that we have demanded of nursing facilities by over 50 percent. We are also doing away with the repetitive questioning on third-party beneficiary cost reports.

I also want to announce a change in the development of the new evaluation and management guidelines that doctors use to bill

Medicare. Physicians found the first sets of guidelines from 1995 and 1997 cumbersome, and we have now been working with a contractor to improve them. But we also want to work with the physicians and the hospitals to identify constructive solutions. And we want to work with Medicare+Choice plans, many of which have complained about Medicare complexity. We want them to participate in Medicare in order to give seniors the same kind of choices that they enjoyed before retiring.

For example, we are taking steps to speed up our review of the plan marketing materials. In addition to implementing the congressionally mandated. Much shorter 10-day turnaround, we are considering the use of other steps to streamline the process for those managed care organizations with good track records of following the rules.

Let me give a final example of the kind of initiative we are undertaking. As administrator Tom Scully has indicated previously in his response to recommendations from Nancy—Congressman Nancy Johnson and Representative Stark —we need to review the patient antidumping requirements. We have directed CMS to go back and revise these regulations, redefine what a hospital is so that they protect patients without creating the unnecessary burden on the hospitals or physicians.

But in addition to streamlining the rules, we can also reduce costs. The President and I believe we must act now to provide immediate assistance to seniors who currently have to pay for prescription drugs. So beginning this fall, on October 1, Medicare beneficiaries will be able to choose among Medicare-endorsed prescription discount cards offered by competing drug discount card programs. Seniors compose virtually the only population in the country that still pays full price for drugs. And under the administration plan, Medicare-approved drug discount cards will create market pressures that will allow seniors to benefit from drug manufacturing rebates and some things they cannot now receive in the discount card markets and, as a result, seniors will be able to get discounts immediately this year up to 25 percent off of retail drug prices. That is real money, real savings in seniors' pockets. And all beneficiaries will be permitted to enroll in one program beginning on or after November 1, about 3 months from now, with discounts beginning in January 2000.

Medicare prescription discount cards would have a one-time enrollment fee no greater than \$25. And this would be a one-time fee to cover the enrollment costs. Some plans have indicated that they do not intend to charge any fee at all. Plans would be required to enroll all seniors who wish to participate and would have to provide a discount on at least one brand and/or generic prescription drug in each therapeutic category. They would have to offer a comprehensive national or regional network of retail pharmacies. And all plans would be required to offer customer service to participating beneficiaries, including a toll free telephone help line, and Medicare would endorse all discount card applicants that meet the qualifying criteria.

But let me be clear, ladies and gentlemen of the Committee. While the discount drug card offers immediate tangible and immediate help to seniors, it is not a substitute for a comprehensive pre-

scription drug benefit, and this is only the first step. Ultimately, we must work together on a broader initiative to strengthen Medicare, to modernize its structure, and to make it more adaptable to the real-world needs of ordinary people.

And that is why the President last week explained his eight core principles that should be at the heart of any comprehensive effort to improve and strengthen Medicare. And here's an outline of those priorities.

First, all seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare. Every senior. About 27 percent of senior beneficiaries have no prescription drug insurance today, and must pay for drugs entirely out of their own pockets or go without needed medication. That is unacceptable, and it will change under the President's leadership.

Second, modernized Medicare should provide better coverage for preventive care, serious illness, and catastrophic diseases. Medicare's preventive benefits should have zero copayments—zero copayments—and should be excluded from the deductible. Medicare's traditional plan should have a single index deductible for Parts A and B, provide a true cost protection for high-cost illness, and take other steps to protect seniors from high expenses for all kinds of health care.

Third, today's beneficiaries and those approaching retirement should have the option of keeping the traditional plan, with no changes, no higher premiums, no changes in cost sharing or supplemental coverage, period.

Fourth, Medicare should provide better health insurance options like those available to all Federal employees. Plans should be able to provide Medicare-required benefits at a competitive price, and beneficiaries who choose less costly options should be able to keep most of the savings, even if that means that they may pay no premium at all.

Fifth, Medicare legislation should strengthen, then, the program's long-term financial security. Between now and 2030 the number of Medicare recipients is expected to increase rapidly from 40 million to 77 million. Medicare relies primarily on payroll and income taxes to finance its benefits. But the significant increase in retirees means that there will be fewer workers to help sustain the Medicare Program. In order to support good planning for the entire program, Medicare's separate trust funds should be unified to provide a clear and meaningful measure of Medicare's overall financial security that is not vulnerable to accounting gimmicks. Financial security cannot be achieved simply by increasing reliance on unspecified financing sources.

Sixth, the management of Medicare should be streamlined so that Medicare can provide better care for seniors. For example, Medicare should be allowed to use competitive bidding tools to improve quality and reduce the cost.

Seventh, Medicare's rules and procedures which we have already started should be updated and streamlined. Instances of fraud and abuse should be substantially reduced, I believe.

Finally, Medicare should encourage high-quality care for all seniors. Medicare must support efforts by plans and providers to improve care through more collaborative programs that use protected

data on quality and safety. Medicare should help seniors get better care through improved information on quality and Medicare should revise its payment system to reward better performance and encourage investments that improve quality of care without increasing budgetary costs.

These are the commitments that President Bush and his administration are making to improve Medicare for every senior. Doing so is not only a political duty, it is a public trust, one I know that we all want on a bipartisan basis to discharge faithfully and effectively.

Thank you, Mr. Chairman and Members. I will be glad to answer your questions.

[The prepared statement of Secretary Thompson follows:]

**Statement of the Hon. Tommy G. Thompson, Secretary, U.S. Department of Health and Human Services**

Chairman Thomas, Congressman Rangel, and distinguished Committee members, thank you for this opportunity to testify before the Committee today. I am pleased to be here to discuss President Bush's framework for modernizing and improving the Medicare program to prepare it for the challenges we face in the coming decades. The President's framework builds on many of the ideas developed by Members of this Committee and other Members of Congress who have long been working to bring the Medicare program up to date, including a prescription drug benefit. The President is committed to working with Congress on a bipartisan basis to enact these principles into law, to help today's seniors and tomorrow's seniors get the coverage they need, and to help keep Medicare's promised benefits secure. I will also describe some additional administrative steps that reflect the President's principles, as well as proposals developed by your Committee on a bipartisan basis. These steps reflect our commitment to take action now to support your bipartisan interest in strengthening the Medicare program.

Medicare has provided health care security for millions of Americans for over thirty-five years. When Medicare was created in 1965, the benefit package was similar to most private health insurance packages of the time. Since then, medicine has changed profoundly and the health insurance options available to most Americans have changed along with it. Yet Medicare's benefit package has in many ways remained rooted in the 1960s. As you all know, outpatient prescription drugs, an increasingly essential part of effective health care, are not included in the benefit package. Coverage for preventive services has also lagged behind developments in private insurance plans. Additionally, Medicare's current cost sharing structure does not include protections for the sickest beneficiaries with the highest medical costs. For example, individuals who need hospital care face deductibles of almost \$800 for each hospital stay, as well as additional cost-sharing requirements (see chart 1). While private health insurance plans generally include stop-loss limits to provide protection against very high medical expenses, Medicare has no such protections. And, as we all know, even Medicare's current benefits are not secure for the retirement of the Baby Boom.

CHART 1

MEDICARE DOES NOT PROTECT AGAINST SERIOUS ILLNESS

	Beneficiary Pays:			
	Days 1-60	Days 61-90	Days 91-150	Over 150 days
Medicare .....	\$792 payment per hospital spell.	\$198 per day ....	\$396 per day ....	All costs
Standard Blue Cross/Blue Shield Plan for Federal Employees.	\$100 payment per hospital admission.	\$0 per day .....	\$0 per day .....	\$0 per day

### **The President's Framework for Strengthening Medicare**

In order to ensure that Medicare will meet the needs of the estimated 77 million Americans who will be beneficiaries of the program by 2030, Medicare must be strengthened and improved. The President has worked with members of Congress from both parties to develop a framework to guide legislative reform efforts to modernize the Medicare program and to keep Medicare's benefits secure.

We believe that reform should be guided by the following set of eight principles:

**1. All seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare.**

Nearly 90 percent of Medicare beneficiaries use at least one prescription drug per year. Yet about 27 percent of beneficiaries have no prescription drug insurance and must pay for drugs entirely out of their own pocket or go without needed medications. A recent study found that Medicare beneficiaries without drug coverage used 8 fewer prescriptions per year than those with coverage; for lower income seniors the gap in utilization was even greater. Low income seniors without coverage used 14 fewer prescriptions per year than those with coverage. While one might hope that the seniors with lower prescription drug costs are simply choosing not to obtain prescription drug coverage, giving seniors quality private-sector prescription drug benefits not only protects them from the risk of high prescription drug expenses, but also helps make all prescription drugs more affordable through innovative tools to reduce their drug costs—by negotiating volume discounts and helping seniors choose the best treatment for them while avoiding adverse drug interactions.

Medicare's subsidized drug benefit should protect seniors against high drug expenses and should give seniors with limited means the additional assistance they need. Seniors should have the opportunity to choose among plans that use the tools widely available in private drug plans to lower costs and improve quality of care. The drug benefit should encourage the continuation of the effective, voluntary coverage now available to many seniors through retiree health plans and private health plans. Today, almost 30 percent of Medicare beneficiaries have employer-provided retiree health coverage, and we must help ensure that employers continue to offer this voluntary benefit. The new drug benefit should also be available through Medigap plans and as a stand-alone drug plan for seniors who prefer these choices. When Medicare implements the drug benefit, states should not face maintenance of effort requirements for their own drug programs outside of Medicaid.

**2. Modernized Medicare should provide better coverage for preventive care and serious illness.**

Medicare has been slow to cover proven treatments for preventing illnesses and saving lives. Coverage often comes long after preventive treatments are widely available in private insurance plans. For example, mammograms were first shown to save lives in the early 1980s by identifying breast cancer that could be treated at an earlier, more curable stage—but Medicare did not cover the recommended annual mammograms until 1998. This Committee understands the value of Medicare preventive benefits and has crafted important legislation in 1997 and again in 2000 to expand preventive benefits for Medicare beneficiaries.

The development of new technologies and new treatments for the most serious illnesses, such as intensive life support for patients with major heart attacks, makes it possible for more seniors to survive potentially fatal illnesses. Unfortunately, Medicare beneficiaries who are sickest often pay the most for their health care costs—exactly the opposite of the way that logical insurance plans work. For example, beneficiaries who incur costs of \$25,000 or more are on average responsible for over \$5,100 in cost-sharing due to Medicare's deductibles, copayments, and coverage limits. With modern technology, such costs are not that uncommon: The cost for treating a patient with heart disease who needs an implantable defibrillator exceeds \$35,000. Patients treated in hospital outpatient departments face copayments that may reach 57 percent of the total payment. So, a typical senior in need of breast reconstruction after a mastectomy would pay coinsurance of \$764, or nearly half of the \$1,563 total payment. For patients with multiple hospital outpatient visits and procedures, the costs can stack up. To protect beneficiaries when they need help the most, private insurance plans generally include "stop-loss" limits. Stop-loss limits provide guaranteed protection against very high medical expenses. Despite its important coverage gaps, Medicare has no stop-loss protection.

We believe that Medicare's existing coverage should be improved so that its benefits provide better protection when serious illnesses occur and provide better coverage to help prevent serious illnesses. These changes should not reduce the overall value of Medicare's existing benefits. Medicare's preventive benefits should have zero copayments and should be excluded from the deductible; Medicare's traditional

plan should have a single indexed deductible for Parts A and B to provide better protection from high expenses for all types of health care; and Medicare should provide better coverage for serious illnesses, through lower copayments for hospitalizations, better coverage for very long acute hospital stays, simplified cost sharing for skilled nursing facility stays, and true stop-loss protection against very high expenses for Medicare-covered services.

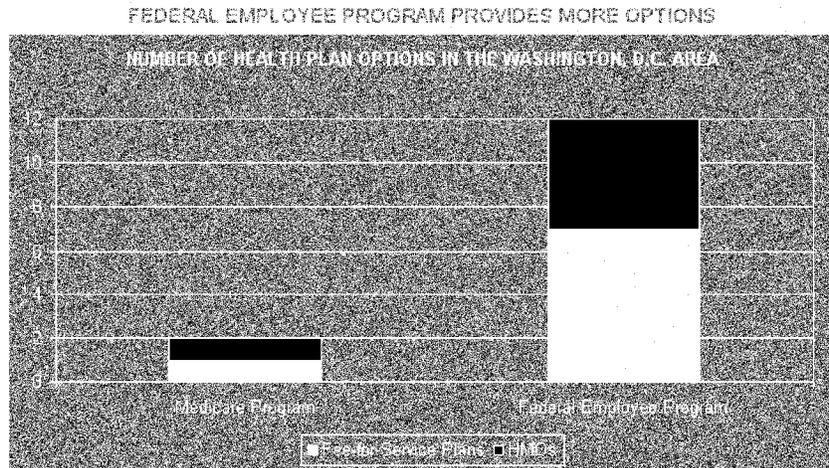
**3. Today’s beneficiaries and those approaching retirement should have the option of keeping the traditional plan with no changes.**

Many people in Medicare today, and others who are approaching retirement, have good supplemental coverage for prescription drugs and other medical expenses. If they wish to continue in the traditional Medicare plan with no changes in their premiums, benefits, or supplemental coverage, they should be able to do so.

**4. Medicare should provide better health insurance options, like those available to all Federal employees.**

Medicare has lagged behind in providing reliable health insurance benefit options for beneficiaries that best meet their own circumstances and preferences. The Federal government, many state governments, and most large private employers help their employees get the care that is best suited to their needs by offering them several health care plans, along with useful information to help them choose the best one for their budget and needs. Medicare has failed to provide America’s seniors with the same kind of reliable health care options that every Federal employee has received for decades—a fact which is particularly evident right here in the Washington area (See chart 2). For many beneficiaries, particularly those in rural areas, Medicare offers only one health insurance plan—it is strictly one-size-fits-all. Previous legislation to address this problem, including the establishment of the Medicare+Choice program, has not had the intended effect of providing more reliable health insurance options for all Medicare beneficiaries.

CHART 2



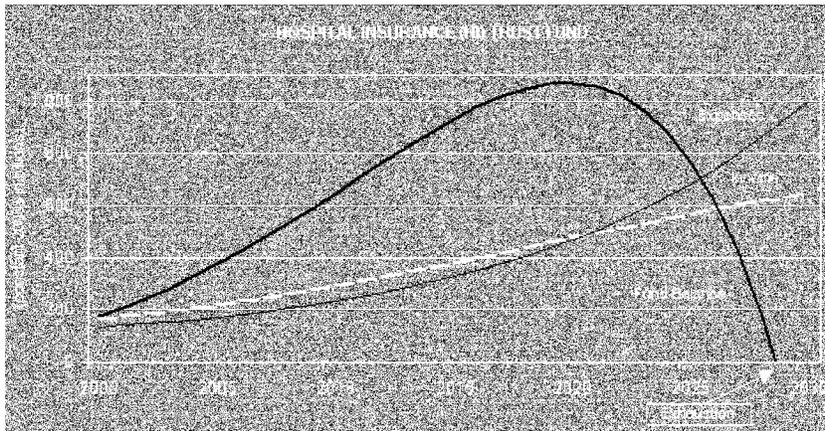
Plans should be able to bid to provide Medicare’s required benefits at a competitive price, and beneficiaries who choose less costly options should be able to keep most of the savings—so that a beneficiary may pay no premium at all. In areas where a significant share of seniors choose to get their benefits through private plans, the government’s share of Medicare costs should eventually reflect the average cost of providing Medicare’s required benefits in the private plans as well as the government plan. Low-income seniors should continue to receive more comprehensive support for their premiums and health care costs.

**5. Medicare legislation should strengthen the program’s long-term financial security.**

Medicare faces substantial financial challenges in the not-too-distant future (see Chart 3). Between now and 2030 the number of Medicare beneficiaries and older

is expected to increase rapidly from 40 million to 77 million. Since Medicare relies primarily on payroll and income taxes to finance its benefits, this increase means that the payroll taxes of fewer workers per beneficiary will be available to support Medicare's covered benefits. Expenses will further rise because health care costs are expected to increase.

CHART 3  
BABY BOOMER RETIREMENT WILL STRAIN MEDICARE



Legislation should strengthen Medicare's ability to plan for and provide its benefit entitlement in the years ahead, thereby improving the program's long-term financial security. To support good planning for the entire program, Medicare's separate trust funds should be unified to provide a straightforward and meaningful measure of Medicare's overall financial security that is not vulnerable to accounting gimmicks. Financial security cannot be achieved simply by increasing reliance on unspecified financing sources.

**6. The management of the government Medicare plan should be strengthened so that it can provide better care for seniors.**

Medicare needs more modern, competitive management tools: the traditional Medicare program has not been able to use competitive approaches to help keep its costs down. Its fee-for-service contracting requirements are outdated, so providers must work with a complex claims processing system that makes it more difficult to serve patients effectively. Contracting reform should be implemented to improve efficiency and performance. In addition, Medicare should be allowed to use competitive bidding tools to improve quality and reduce costs for durable medical equipment, prosthetics and orthotics, and clinical lab services—provided that the government plan is not allowed to create new price controls and that seniors continue to have choices.

Medicare needs more modern medical management tools: traditional Medicare does not provide efficient integrated services for many seniors who need support for managing their illnesses, particularly in the case of chronic disease. Beneficiaries who wish to participate in innovative programs such as disease management should be able to do so. Finally, Medicare's process for covering new technologies should be streamlined.

**7. Medicare's regulations and administrative procedures should be updated and streamlined, while the instances of fraud and abuse should be reduced.**

Medicare is a complex system of ever-changing rules and regulations that affect 40 million beneficiaries and over one million physicians and other health care providers who serve them. Patients and providers face variable and inconsistent policy interpretations from various contractors and from different offices with overlapping jurisdictions within the Federal government itself. Rules may vary across areas and over time.

Complexity, variability, constant changes, and the existence of some rules that are just not workable all contribute to the need to reduce regulatory and administrative burdens in Medicare. Needed relief in regulation and oversight should be implemented and I will discuss some new initiatives later in my testimony. This will allow providers to spend more time and effort on patient care and less on paperwork while continuing to ensure the integrity of Medicare funds.

#### **8. Medicare should encourage high-quality health care for all seniors.**

Medicare's most important goal should be to enable seniors and disabled Americans to get the high quality error-free health care they deserve. Currently, there are too many instances where beneficiaries fail to get recommended treatments, and there are too many instances of beneficiaries being hurt by medical errors.

Medicare should support efforts by plans and providers to improve care through more collaborative programs that use protected data on quality and safety. Medicare should help seniors get better care through improved information on quality. Medicare should revise its payment system to reward better performance and encourage investments that improve quality of care without increasing budgetary costs. Medicare's risk adjustment system for private plans should reward health plans for treating the toughest cases and finding innovative ways to provide care and reduce complications for chronically ill, high cost patients. Medicare should address the additional challenges facing rural health care providers in delivering high-quality care.

#### **TAKING ACTION NOW**

These are the principles that the President wants to see embodied in legislation to strengthen and improve Medicare. To help seniors and pave the way for these future improvements, we are also committed to taking the steps we can administratively—in many cases, to take advantage of flexibility that Congress has wisely provided in the past. I would like to discuss two main areas of administrative action. First, I want to talk about our initiative to give all Medicare beneficiaries access to the kind of discounts that a competitive system can provide them—the system that is incorporated in all of the major Medicare drug benefit proposals pending before Congress. Second, I want to talk about our efforts to provide regulatory relief—so that fraud and abuse of the Medicare program can be reduced even as doctors gain more time to spend with their patients.

**MEDICARE RX DISCOUNT CARD**—While the Administration believes that the addition of a Medicare prescription drug benefit should be included within an integrated modernization of the Medicare program, we intend to act now to provide immediate assistance to Medicare beneficiaries currently without prescription drug coverage. Because beneficiaries without coverage often have no source of bargaining power, they often pay higher retail prices for their medications. Beginning this fall, Medicare beneficiaries will be able to choose among Medicare-endorsed Rx discount cards, offered by competing drug discount card programs. These cards will provide a mechanism for beneficiaries to gain access to the effective tools widely used by private health insurance plans to negotiate lower drug prices and provide higher-quality pharmaceutical care. Discount cards are currently available in the marketplace through a variety of sources, including pharmacy benefit managers (PBMs), some Medigap insurers, and retail drugstores. People with Medicare would be able to use the cards when they buy prescriptions to get discounts of perhaps between 10–25 percent off retail prices.

All beneficiaries will be permitted to enroll in one program beginning on or after November 1, 2001 with discounts beginning in January 2002. Medicare-endorsed discount card programs will conduct marketing and enrollment activities, aided by support from the Centers for Medicare & Medicaid Services (CMS). Enrollment is limited to Medicare beneficiaries and beneficiaries will be permitted to enroll in only one Medicare discount card program at a time.

We believe this initiative will provide a number of additional benefits for seniors that many of them do not enjoy now:

- First, we believe that providing comparative information to the elderly and disabled about actual drug prices will spur greater competition and lower prices than we see today.
- Second, we believe these cards will create market pressures that will allow Medicare beneficiaries to benefit from drug manufacturers' rebates—something most seniors cannot obtain currently in the discount card market now.
- Third, we believe these competitive pressures will lead to other innovations that improve quality and patient safety—like broader availability of the computer programs to identify adverse drug interactions, and better advice on how seniors can meet their prescription drug needs at a more affordable cost.

Medicare Rx Discount Cards would have to meet several qualifications to receive Medicare endorsement:

- Plan sponsors could charge an enrollment fee no greater than 25 dollars. This would be a one-time fee to cover enrollment costs. Some plans may not charge any fee.
- Plans would be required to enroll all beneficiaries who wish to participate.
- Plans would have to provide a discount on at least one brand and/or generic prescription drug in each therapeutic class.
- Plans would have to offer a broad national or regional network of retail pharmacies.
- Plans would be required to offer customer service to participating beneficiaries, including a toll-free telephone help line.
- All discount card applicants that meet the qualifying criteria would be endorsed by Medicare.

**Regulatory Relief**—As you know, I am taking aggressive steps to bring a culture of responsiveness to all of HHS. The Center for Medicare and Medicaid Services (CMS) is one of the Department's largest agencies, providing health benefits to more than 70 million Americans. This year alone the Medicare, Medicaid, and SCHIP programs will pay an estimated \$476 billion in benefits, and each year Medicare alone processes nearly one billion claims from over one million physicians and other health care providers.

Medicare and Medicaid are wonderful programs, but they are huge and they are complex. Their rules generate many of the concerns that our constituents bring to your attention and mine. Of course, there is a genuine need for rules and regulations. But rules should exist to help, not hinder, our efforts to assist people, and help control costs and ensure quality. When regulations, mandates, and paperwork obscure or even thwart the help providers are trying to give, those rules need to be changed. Our constituents, the Americans who depend on Medicare and Medicaid, the physicians and other health care providers who care for them, and the American taxpayers who fund the program deserve better. And so, I am working with the Office of the Assistant Secretary for Planning and Evaluation and CMS to reform the way Medicare works, making it simpler and easier for everyone involved, as well as simplifying other departmental regulations. We are dedicating ourselves to listening closely to Americans' concerns, learning how we can do a better job of meeting their needs, and serving them in the best way we can.

As I announced last month at Northwestern University Hospital, I am doing a top to bottom review of the agencies and looking for opportunities to streamline regulations without increasing costs or compromising quality. To this end, I am calling for a new regulatory reform initiative to look for regulations that prevent hospitals, physicians and other health care providers from helping people in the most effective way possible. This initiative will determine what rules need to be better explained, what rules need to be streamlined and what rules need to be cut altogether while still providing beneficiaries with high quality care and protecting the interests of taxpayers. And to implement this initiative, I have developed a three-pronged approach that will get us on the right track, to listening, to learning, and then to administering all federal health care programs as effectively as possible.

Under the first prong of my plan, we are going to start listening more to the public. This spring, I actually moved my office to CMS headquarters in Baltimore for a week to get acquainted with the inner workings of the Agency. I learned a lot, and at the end of the week I had an amazing listening session with actual Medicare beneficiaries and others to hear what they had to say about Medicare—talk about learning a lot!

While people really like Medicare and Medicaid, they have a lot of suggestions for improving them. We need to do more of this type of listening. And so I am directing CMS to start holding more listening sessions out in the field, away from Washington, DC and away from Baltimore, and out in the areas where people have to live and work under the rules we develop. These people may not have such easy access to policymakers to share their good ideas and concerns. Most of you in Congress have these kinds of listening sessions with your local constituents on a regular basis. I did this all the time as Governor of Wisconsin, and I can't begin to explain how useful it was. I want our people in CMS to hear from local seniors, the disabled, large and small providers, State workers, and the people who deal with Medicare and Medicaid in the real world. I want to get their input so we can run these programs in ways that make sense for real Americans in everyday life. We hear from some of these people now, but I want to get input from many, many more.

Some of the people who we hear from the most are the individual and institutional providers who are dealing with our rules every day. They are the ones caring

for our beneficiaries, and they are the ones filling out many of the forms, trying to understand the rules, and working to do the things they spent years training to do—making people healthy. And so the second prong of my approach will focus specifically on their expertise. I am going to convene seven health sector workgroups to suggest ways that we can improve their interactions with CMS and the Medicare program to reduce regulatory complexities and burdens. For example, the American Hospital Association recently released a report, “Patients or Paperwork: The Regulatory Burden Facing Hospitals.” It found that the regulatory burden means that every hour spent providing actual patient care generates at least 30 minutes—and sometimes an hour—of paperwork. We need to do more to address burdens like this to improve our operation of Medicare, so that health care professionals can spend more time delivering the care for which they were trained, and so that beneficiaries can spend more time with their doctors and other providers—not in waiting rooms.

I want to hear from the broad range of providers, from those in rural offices and inner city clinics to the suburban health centers and urban hospitals. I want to hear from the large hospital systems and the small, two doctor practices and the solo providers. I want input from folks like medical equipment providers, group practice managers, physician assistants, and nurses—for example, we have an emerging health care professional (particularly nurses) shortage crisis in parts of America today, and I want to hear good ideas for how to fix it. These professionals who are in the field every day can give us good ideas that improve our management of these vitally important programs. This type of input is good for our beneficiaries not only because regulatory reform will allow physicians and providers to spend more time caring for beneficiaries, but also because it will encourage physicians and providers to remain in the Medicare program. To ensure that CMS responds to these ideas and comments, a senior level staff person has been assigned to each provider industry.

In no way will we diminish our interest in fighting waste fraud and abuse. The vast majority of providers are only interested in delivering needed care, but for the small percentage of people who take advantage of the system, we will continue our aggressive efforts to protect the funds that taxpayers have entrusted to our use.

Like the physicians, providers, and beneficiaries who live and work with Medicare every day, the Department’s staff have dealt with the system for years, and they have suggestions about how we can operate the Medicare program more simply and effectively. They certainly have heard from all of you and from many, many providers about what could be fixed. To examine these important concerns, I am forming a group of in-house experts from the wide array of Medicare’s program areas, and I am asking them to think innovatively about new ways of doing business, reducing administrative burdens, and simplifying our rules and regulations. Today, providers are forced to spend more time keeping up with the latest rules and interpretations rather than keeping up with providing patient care. And frankly, the complexity of the program makes it difficult for those of us who administer it to keep up. It is difficult to educate beneficiaries and our business partners when there is so much complex information to explain. And it is hard to appropriately target fraud and abuse without unfairly burdening the vast majority of honest physicians and other providers. This group of experts will develop ways that we can reduce burden on providers without increasing Federal costs or undermining quality of care, eliminate complexity wherever possible, and make Medicare and Medicaid more “user-friendly” for everyone involved.

These outreach efforts will allow us to hear from all of these different segments of people who deal with Medicare and Medicaid, from the beneficiaries and the public at large to the physicians and providers to the Department’s employees. We are going to listen to them, and we are going to learn how we can do a better job. But listening is not enough. Getting together and generating great solutions is not enough. So we are going to take action. We are going to use all of this wonderful input, and we are going to improve the way we do business and make Medicare and Medicaid easier for everyone involved with them. I have already started by taking some bold steps based on feedback we have received from the public:

#### **Improvements for Hospitals and Skilled Nursing Facilities**

I am eliminating unnecessary data that has been demanded of hospitals and skilled nursing facilities in their Medicare Cost Reports. There is a statutory requirement that, for payment, hospitals report their overhead for old capital costs and new capital costs. We will eliminate these reporting requirements for most hospitals as soon as we can after September 30, 2001, when they expire in law. This will shrink the cost report by about 10 percent. This is not enough, but it is a start, and we plan to do more.

There also is a questionnaire, called form 339, that providers currently have to fill out with their cost report. It requires information on office expenses, deferred compensation, and other data not required in the cost report. This seems kind of crazy to me, to have to do an extensive report and then to have yet a different questionnaire on top of the report. And I understand that some of the questions on this form request information we do not even need from some providers. So we are going to eliminate a number of them, and we are going to fold the ones we do need into the cost report. This will give us one form, not two, to collect only the information we need, not the information we don't need. While providers will still have to answer some of these questions for the report, at least there will be less of them, and the report and the questions will all be in one place. This is one example of the little things about working with Medicare that drive providers crazy, and we are working hard to make it better.

Similarly, under the law we have been paying skilled nursing facilities by blending cost-based and prospective payment systems. This has required providers to collect a lot of data and perform extensive calculations on the cost reports. Starting this month, the law requires all of these facilities to be paid 100 percent prospectively. That means we no longer need all of those calculations. We will therefore look to simplify cost reporting for SNFs.

At the same time we are working to eliminate unnecessary requirements, we have new requirements to contend with. For example, the BBRA requires hospitals to report some new data on their cost reports for periods beginning on and after October 1, 2001. So we have to continue to search for ways to make the work simpler where we can. We have established regulatory reform workgroups to further review these and other regulatory reporting requirements to determine what further improvements we can make. And I will hope to hear from many other people and to work with this Committee and Congress to get even more ideas on making these cost reports more sensible and easier to complete.

#### **Improvements for Physicians**

Another bold step that I want to announce today is a change in our development of the new Evaluation and Management (E&M) guidelines that physicians use to bill Medicare for their doctor visits. We know that physicians' primary work is to provide clinical care, not documentation. We have been working on a third version of these guidelines, which are based on the AMA's Current Procedural Terminology (CPT) that physicians use to bill insurance companies. Physicians found the first two sets of guidelines, developed in 1995 and 1997, cumbersome. We agree, and have been working with a contractor, Aspen Systems, to improve them, but physicians have continued to express concern that these guidelines are hindering, not helping, the delivery of appropriate patient care.

We had hoped that this current effort would be a way to reduce burdens on physicians, but it appears it needs another look. So I have directed Aspen Systems to stop their work on this current draft while we reassess and re-tune our effort. Additionally, I am turning to the physician community to help design constructive solutions. After six years of confusion, I think it makes sense to try to step back and assess what we are trying to achieve. We need to go back and re-examine the actual codes for billing doctor visits. For the system to work, the codes for billing these visits need to be simple and unambiguous. I look forward to working with the AMA and other physician groups to simplify the codes and make them as understandable as possible.

#### **Improvements for Medicare+Choice Plans**

In addition to working with physicians, we also want to work with our Medicare+Choice plans. Many of these plans have complained about the complexity of the program, and justifiably so. We want to facilitate participation of high-quality plans in Medicare to give beneficiaries more stable choices like the ones many Americans enjoy before retiring. For example, we are taking steps to speed up our review of plan marketing materials to ensure that seniors have timely and accurate information. In addition to implementing the Congressionally mandated, much shorter 10 day turnaround, for this fall's contracting cycle we intend to streamline the process of reviewing marketing materials. Following the fall contracting cycle, CMS will examine the success of this process with the hope that it can be expanded to possibly include other marketing materials throughout the contract year. We also will consider performing targeted reviews of marketing materials only for those managed care organizations that have solid track records, including histories of complying with CMS requirements. We are exploring authorities and flexibilities to focus on monitoring and oversight of those plans that need the most attention. Additionally, we also hope to streamline the way plans report the financial risks that

they impose on their participating physicians. Currently, these annual reporting requirements are extremely detailed and complex, and we want to find less burdensome alternatives for reporting this information. We also intend to clarify requirements that plans provide marketing information about competing plans in their area.

As in systems that have been successful at providing reliable, high-quality plan choices, like the Federal Employees' system, the Medicare program should take the responsibility to provide reliable, unbiased information for seniors on their coverage options and patient rights. To help us provide the information that seniors need, we will conduct a \$35 million education and advertising campaign this fall.

All these ideas build on the valuable bipartisan suggestions of this committee for improving the Medicare program, contained in a useful set of recommendations to CMS Administrator Scully from subcommittee Chairman Johnson and Representative Stark. I would like to elaborate further on some of your specific ideas.

One such area that really needs another look relates to the patient anti-dumping requirements. These requirements were intended to ensure that patients in emergencies, including women in active labor, were not turned away from hospital emergency rooms because of lack of insurance. While the law in this area is well intentioned, we understand that providers view the current regulations as burdensome. I have directed CMS to go back and revise these regulations and make any necessary changes to ensure they protect patients without creating unnecessary burdens on the hospitals or physicians.

Another idea is contractor reform. As you know, the Administration has presented a specific legislative proposal to enable Medicare to process claims in a more responsive and efficient way.

We are also implementing your ideas for "frequently asked question" support for beneficiaries, for using on-line tools to improve the efficiency of Medicare+Choice enrollment and other program activities.

We will continue to work with you to do more. I think you will find, as I have said many times before, the excuse for doing things because "that's the way we've always done it" isn't going to work anymore. I am committed to changing things. I am confident that our new approach will go a long way toward making Medicare and Medicaid more user-friendly. I am genuinely excited about the progress we are going to make, and I am confident that we can build on these steps to enact the legislation to improve Medicare that is overdue.

### **Conclusion**

While we regard the Medicare Rx Discount Card and our regulatory relief efforts as an important first step to provide immediate assistance to Medicare beneficiaries and to improve the program for them, I want to reiterate the importance that the Administration attaches to the need for broader Medicare improvements, based on the President's eight principles that I have outlined here. The discount card is only a first step, not a substitute for comprehensive prescription drug benefit combined with other needed legislative reforms. I stand ready to continue to work with you in a bipartisan fashion to strengthen the Medicare program, modernize the benefit package, strengthen its financial underpinnings, and provide access to high quality, innovative treatments for our nation's seniors and disabled populations now and in the future.

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Chairman THOMAS. I thank you very much, Mr. Secretary.

As was indicated in the opening remarks of some of my colleagues, the idea of moving administratively, apparently, is something that my colleagues are not as familiar with as they should have been. To me it's ironic that for the 8 years of the previous administration, and especially in the last 3 or 4, and the intense discussion about trying to provide prescription drugs to seniors, and especially those who are forced to pay retail as seniors, had to be played out in the legislative arena exclusively and which, without the passage of legislation, nothing could be done for seniors is just amazingly false; because as you have indicated, this administration focused on actually doing something about the problem rather than running on the problem for political purposes, and has already

moved administratively to provide, admittedly, a modest reduction in the price for seniors, and you have done it administratively. I want to compliment you on that.

In the last Congress we attempted to move legislatively a prescription drug program. We were required in that legislation to attempt to change the structure of the Health Care Financing Administration through legislation to create a structure that would negotiate prices for prescription drugs and for Medicare+Choice prices.

Now, the benefit of a competitive negotiated model in prescription drugs, the Congressional Budget Office (CBO) indicated to us, was a double or triple savings over a single-model non-negotiated plan which was, of course, the administration's.

So my focus would be one, thank you for the rapid administrative move to provide an initial reduction in costs to seniors; but, have you, one, administratively structured the former Health Care Financing Administration—now the Centers for Medicare Services—to create a structure that would allow competitive bidding? And does the President's plan envision a competitive prescription drug program which would get those savings through placing some of the plans at risk and forcing a competitive model?

I repeat, all that was required to be done legislatively in the previous administration. How much of this can be done administratively from your side, Mr. Secretary?

Secretary THOMPSON. We are looking at all of those things, Mr. Chairman. We are moving as rapidly as we possibly can to provide the competition to provide for improvements, simplifying the rules and the regulations so that Medicare+Choice can stay in the market, which has been a difficulty. And we are doing the same thing in the area of hospitals and providers and we will continue to do so. We think that all of the things we have done so far are within the confines of our ability to get that done, and we will continue to do so. We will continue to come back to this Committee and to other Members of the House and the Senate in order to share with you our concerns if we run into problems, but also share with you our results and what we intend to do.

Chairman THOMAS. It's ironic that the reward for moving rapidly in an administrative manner is to be sued. I look forward to working with you. I hope you continue to advance the administrative changes. And when you have run the string out, it will be our goal to provide you with additional opportunities to continue to make changes administratively, and, where necessary, work with you cooperatively to do the required legislative changes, so that instead of a hope and a promise, we can actually deliver a modernized Medicare, with prescription drugs for all seniors and disabled under Medicare. I thank you very much.

The gentleman from New York.

Secretary THOMPSON. Thank you Mr. Chairman.

Mr. RANGEL. Thank you Mr. Chairman. I partially agree with the Chairman in terms of supporting the administrative initiatives that the President has expressed. But I am just a little too old to wait for that string to run out before we provide a legislative solution.

The only problem I had with the President's announcement of the principles was that it appeared as though this was a major initiative. The problem, Mr. Secretary, is that any time someone starts talking about giving assistance for prescription drugs, older people and people with less income and fixed income really believe that we have taken care of the problem. They don't distinguish between the President and the Congress. They want help.

And so this is relief and we should laud it. But we have to make certain that we don't give the impression that we resolved the problem. And I don't think you have either. And so Mr. Thomas is

a lot younger than me, he can wait for these strings to run out. But I am certain that the President, when he was campaigning, wasn't talking about these strings running out. He said together he will work with the Congress and provide quality care and, at the same time, that it would be fiscally responsible.

Now, in your testimony, you talk about the soundness of the Medicare system, and one of those principles is strengthening the program's long-term financial security. The Part B—strike that. The Medicare Hospital Insurance Trust Fund, in your opinion, what is its fiscal position?

Secretary THOMPSON. Part A are you talking about?

Mr. RANGEL. Part A.

Secretary THOMPSON. Part A is running a surplus at the present time, and Part B is running a deficit.

Mr. RANGEL. Now, Part A has never been in better shape in 57 years, and it is solvent to 2029, and we have to monitor that very carefully. How can Part B, just for purposes of understanding, how can they be running a deficit when it is not an entitlement? It is supported by general revenues. And I don't know any other program that goes before the Appropriations Committee that we can say, as citizens or as lawmakers, that is in a deficit.

Chairman THOMAS. Will the gentleman yield briefly?

Mr. RANGEL. I hate to do that because I always see you, but I very seldom have a chance—

Chairman THOMAS. I don't want to interrupt the gentleman's rhythm. But I don't know whether he misspoke when he said that Medicare was not an entitlement. Medicare is an entitlement, and I believe the record would show —

Mr. RANGEL. Well, I misspoke.

Chairman THOMAS. Thank you.

Secretary THOMPSON. Part B is also financed by premiums.

Chairman THOMAS. I just want to make sure that no one listening to us believes that this Committee is not an entitlement.

Mr. RANGEL. Medicare Part B is an entitlement. I want to know if it is funded in part by general revenues, how can we say it has a deficit? That is what I want. I apologize, because I thought that you were going to get involved in that. But you are right. And my question is if Part B is in part funded by general revenues, which we have to go to the Appropriations Committee to get, how can we say now it runs in a deficit?

Secretary THOMPSON. As you know, Congressman, in 1997, Part A was in less good financial shape.

Mr. RANGEL. Yes.

Secretary THOMPSON. And this Congress passed legislation that transferred home health to Part B. And that solidified Part A to be more financially secure up to 2029 with that change. Part B, when you include Part B and Part A together, which this administration believes is the right thing to do and—and now this can be debatable. But we feel as an administration, in order to put Medicare on a sound fiscal footing, you have to look not only at Part A and Part B in separate avenues, you have to look at it as a total package. And when you look at a total package, the amount of expenditures for the operation of Part B exceeds the income by approximately \$700 million. And Part A exceeds the outgoes by about

\$500 million. And so there is a deficit when you combine A and Part B.

Mr. RANGEL. Now, you are kind of changing the accounting rules in order to reach that conclusion. So rather than challenge what you would like to do in combining Part A and Part B for determining its fiscal standing, it would seem to me that the only way to bring Part B into balance is that you would consider either reducing provider benefits, reducing the beneficiaries' benefits, or increasing the payroll taxes. Now, the President has ruled out the latter, and I don't see—if we are not going to the Appropriations Committee, how do you intend to bring about this fiscal balance with part B?

Secretary THOMPSON. We think—and we have looked at it in many different ways, Congressman—that with the eight principles that I have outlined and which the President articulated last Thursday, and by combining part A and B, that we put it on a financially secure footing. And we will be able to do it with the principles, with working with you, and with working with the other Members of the House and Senate.

Mr. RANGEL. OK. You have already disregarded the payroll increases, right?

Secretary THOMPSON. That is correct.

Mr. RANGEL. Have you disregarded reduction in benefits?

Secretary THOMPSON. Yes, we have.

Mr. RANGEL. Have you disregarded reducing the provider's obligations?

Secretary THOMPSON. We have—we are making changes. We are streamlining them and making them more efficient, Congressman.

Mr. RANGEL. Thank you.

Chairman THOMAS. The gentleman from Illinois wish to inquire?

Mr. CRANE. Thank you Mr. Chairman.

Mr. Secretary, in your testimony this morning you state, quote, Medicare should help seniors get better care through improved information on quality. Medicare should revise its payment system to reward better performance and encourage investments that improve the quality of care without increasing budgetary costs.

And I think we are all supportive of increasing the quality of care for all beneficiaries, but could you please elaborate on how this administration would revise its payment system without increasing budgetary cost to reward performance? And I am particularly interested in what the quality indicators might be and how they might be applied.

Secretary THOMPSON. Well, there are many ways in which we expect to do that, Congressman. First off, in adding more preventive health coverage; being able to get to seniors sooner; more diagnostic treatments; better nutrition and so on, which we hope to be able to put into new proposals to strengthen Medicare, would reduce the amount of cost.

Number two, we expect to find ways to automate and put in place new technologies to make the administration of hospitals and clinics more efficient; therefore, being able to reduce the cost.

Number three, we are trying to find ways to simplify the rules and regulations in the contracting out, in allowing us more flexibility to contract, which would reduce the cost.

And fifth and finally, we hope with the new technology, we would be able to reduce doctors' mistakes and be able to improve the quality.

All of these things are under review. A lot of these things are under Committee study right now, and we are expecting to make a lot of suggestions to this Committee to other Members to accomplish just what we have pointed out in our principles, and hope to work with you on a bipartisan basis to develop a proposal that will strengthen all of the things that I have mentioned.

Mr. CRANE. Thank you, Mr. Secretary. I yield back the balance of my time.

Chairman THOMAS. Thank the gentleman. The gentleman from Florida wish to inquire?

Mr. SHAW. Yeah. Mr. Secretary, it is interesting because I had turned to the same part of your statement that Mr. Crane just read from, talking about better performance and encouraging investments to improve the quality of care. One of those matters we introduced last year and was passed and it has to do with digital mammography. Mr. Kleczka and I worked together to have that included so that the fee structure for mammography would reflect this added technology. Obviously, that is an added cost initially. But from the answer that you just gave to Mr. Crane, you certainly acknowledge that better and earlier diagnosis of these things can, in the long run, actually give us some tremendous savings.

Early diagnosis, particularly in the area of cancer and breast cancer, is tremendously important. It can have the—it can make the difference between a lumpectomy and a mastectomy. It can mean the difference as to what type of after care is necessary with some of the very tough areas as chemotherapy and radiation and all of those things that follow that.

So I am very much encouraged by your comments with regard to the—with use of the new technology and recognizing that we need to really work and get into that.

Another area that I think we need to take a good hard look at is, again, in the area of dealing with women and being sure that they have access to the very, very latest. When you get into pap smear tests, I think these are very important for particularly some women who are considered to be high risk. Every other year is not enough. We should work toward putting women who are at high risk and allowing them to have that test every year.

I believe under current law that men certainly can have the prostate examination every year, and when you get to be a certain age, I understand that if you live long enough every male will have it.

Secretary THOMPSON. That is correct.

Mr. SHAW. And I think that, even though I understand that age doesn't necessarily increase the risk of cervical cancer, that we should recognize, though, that some women who are at greater risk should have more frequent tests. Would you like to comment on that?

Secretary THOMPSON. Well, thank you so very much, Congressman. Let me just quickly respond to a couple of your points. First, in regards to digital mammography and the new digital machines, it is one of those breakthrough technologies that we need to do more about, and we need to be able to use the Medicare system

and the hospital system for best practices. And what you and Congressman Kleczka have done in regards to that, I compliment you.

And one of the final things I did as Governor of the State of Wisconsin before I left to take this job is to purchase two new digital mammography machines for the University of Wisconsin hospital. And it's the right thing to do.

With regard to women's health it is so important for us to expand women's health in America. Because women, and as head of households, purchase—80 percent of the medical dollars are spent through their purchases. We have to make sure they are well informed and, through a good women's health program at the national level and at the State level, I think we can make a lot of progress.

The third and most important that you were mentioning is on preventive health. And this Committee has been acknowledged as one of those Committees that has been very visionary in looking forward to find ways to come up with preventive health measures, and I compliment the Committee for doing that. I'm trying to develop in the Department a whole new philosophy on preventative health. I think it's the most important thing that we can do to hold down medical costs in the future, and to develop reimbursement systems along encouraging preventative health measures. And I can't tell you—this is an item that I have a great deal of passion for and I am very pleased that you raised it because it is something we badly need, and I am very pleased that the President put this in as one of his main principles on the redevelopment and strengthening of Medicare systems in America.

Mr. SHAW. I just have one other comment before I yield back my time. And it's wonderful to have someone like you who recognizes the importance of Governors and States and coordination with us at the Federal level. You certainly were invaluable in rewriting the welfare laws for this country, which has profited so many of the less fortunate and made them productive human beings again. And I recall working with you and you were very, very appreciative of the fact that we were reaching out to the Governors, and there is a world of knowledge out there and a world of experience and I am glad to see you where you are.

Thank you, Mr. Secretary, and I yield back.

Secretary THOMPSON. Thank you very much, Congressman Shaw.

Chairman THOMAS. Thank the gentleman. Gentleman from California, Mr. Stark, wish to inquire?

Mr. STARK. Thank you Mr. Chairman.

Mr. Secretary, getting back to this drug card, it's my understanding that these applications like the discount card program require a clearance under the Paperwork Reduction Act, and there is a note on your Web site that the application is pending OMB approval; and you're saying the applications are due from these drug companies on August 27. That is 45 days. But your internal documents suggest that following normal procedures, it would take 160 days for the—for you to go through the Paperwork Reduction Act process. How is that— how do you work that out?

Secretary THOMPSON. Well, this—

Mr. STARK. Are you avoiding the Paperwork Reduction Act?

Secretary THOMPSON. No, we are not, Congressman. But what we are doing is we are using this as a payment measure, a reimbursement thing.

Mr. STARK. No. I just wondered—any of these plans requiring the Paperwork Reduction Act, according to your own internal memos, about a minimum of 160 days, and I just wondered how you were getting it done in 45 days rather than 160.

The other question is that you are required under the Federal Advisory Committee Act to publish notices in the Federal Register at least 15 days in advance of holding a meeting that comments on this. And I am wondering if you or Mr. Scully met with any of the pharmaceutical benefits managers (PBMs), Merck, or Managed Care LLC, or Express Scripts, or Caremark, or WellPoint prior to working out this plan.

Secretary THOMPSON. Absolutely not.

Mr. STARK. You never met with any of them.

Secretary THOMPSON. We have not, Congressman. We met with them the day that—I believe Tom Scully, you can ask him directly. But I believe the administrator, Tom Scully, met with them on the day before it was announced. But in regards to pulling together the program, it was done internally, Congressman.

Mr. STARK. No lobbyists, no Debra Steelman, no lobbyists from Pharma, you never meet with anybody—

Secretary THOMPSON. I can only speak for myself. I did not, Congressman Stark. This was something that—

Mr. STARK. You know that would be against the law, don't you?

Secretary THOMPSON. Yes, I do, and I did not meet with them.

Mr. STARK. We will get Scully later in deposition. I would rather, if you want to swear him, I would be glad to bring him to the mike.

Mr. STARK. Mr. Secretary, one of the things you are talking about in combining these trust funds is a common deductible. How much would you estimate the new deductible would be?

Secretary THOMPSON. We have not costed it out, Congressman, at this point in time. We want to work with you and other Members of this Committee. We have set out the principles. We would like to have a unified discussion. But we have not—

Mr. STARK. Would you agree it should be kept below \$100.

Secretary THOMPSON. I don't want to make that statement today, Congressman.

Mr. STARK. Because it is estimated that it would be \$400, and 80 percent of the Medicare beneficiaries use Part B where they only pay \$100 deductible. Only 20 percent of the Medicare beneficiaries use Part A and they got an \$800 deductible. So if you raise that common deductible above a hundred bucks you are basically penalizing four out of five beneficiaries by raising their deductible. Are you aware of that?

Secretary THOMPSON. I am fully aware of what you are saying, Congressman Stark. I would also like to point out what we are trying to do, we are trying to strengthen Medicare. We are trying to add some additional benefits. We are also trying to have one deductible.

Mr. STARK. How do you do that without putting any more money into the program? What kind of magic—I mean, I understand this Buck Rogers card here won't save anybody any money, but how do

you strengthen the program without either cutting benefits as the managed care plans do today to make a profit, or cutting back the payment to providers, because you are not mentioning putting any more revenue in this program? You are not suggesting—you are cutting benefits or cutting back payments to providers in an effort to privatize the plan, to free up the general revenues because you want to—you are not talking about a specified source of money for the Department of Defense, and yet we are going to fund them every year.

Why should part B have some specified source? Why shouldn't we just understand that since 1965 seniors have come to depend on Medicare and that the Republican administration wants to privatize it, turn it back into an insurance program to benefit the American Association of Health Plans and stick it to the seniors. That is what your plan does, and that is what these principles do, and you know it full well.

Secretary THOMPSON. Congressman Stark, I would like to respond if I might be able to. You can use your harsh language any way you want to try and demonize this plan. I am here to tell you that one of the number one things that the President said is that every senior should be able to be covered. Every senior should have a choice to be able to stay in the plan that they want or the newly defined plan. And they will have that choice, just like you have a choice, like I have a choice and everybody that is covered.

We did not want to turn this into a partisan thing. I think we are coming in front of you and we are here to offer what we think is a very constructive suggestion. I would love to be able to work with you, and I would love to be able to tell you and I am as passionate about helping seniors as you are. And I am a Republican and you are a Democrat. And I think we should forget about that when we are working on this subject and see if we can't come together and come up with a very constructive, positive, new, strengthened Medicare with additional benefits. And if you are willing to do that, I certainly am, and I think we can accomplish both of our objectives.

Chairman THOMAS. The gentleman's time has expired.

Mr. STARK. The indications so far haven't been that. You haven't been forthcoming with us. You have had secret meetings that the Democrats haven't been included in, and that is no way to start out on a bipartisan basis.

Secretary THOMPSON. I have met with many Democrat Congressman and Senators. In fact, I am meeting with a lot of them this afternoon. Most of the people that I have met with have actually been D's rather than R's on this subject.

Chairman THOMAS. The gentlewoman from Connecticut, the Chairwoman of the Health Subcommittee, wish to inquire?

Mrs. JOHNSON of Connecticut. Thank you. I would like to welcome you, Mr. Secretary, to the Ways and Means Committee and thank you for working with us on a lot of administrative reforms that frankly are extremely important to the sheer survival of the small providers out in the rural areas, the small towns, and the neighborhoods of our cities. If we don't move aggressively on administrative reform, we will not have the delivery system that our seniors need and all other Americans depend upon.

But I also want to commend you on the vision you put before us. Now that isn't to say that we all agree on exactly how we can get there, and it also isn't to say that we all agree on the pace at which we can get there. But not to acknowledge the bigness of the vision that is embodied in your testimony and that the President is discussing is to weaken ourselves, whether we are Democrats or Republicans, because we have had a terrible time providing preventative benefits to seniors under Medicare under the old system.

You know it took us 5 years to get mammograms. That is just terrible. You know, pap smears last year. It is disgraceful. So your focus on preventative health is something we have got to take seriously and think through seriously.

The other thing that you have offered that neither party has had the courage to talk about is that a catastrophic level prescription drugs is nice but a catastrophic protection against all health care costs is frankly what the future is going to demand of us in Medicare. And if we can get and—and we don't know yet and Mr. Stark doesn't know and I don't know to what extent we could offer the seniors of America real protection against a catastrophic level of expenses, not just prescription drugs, across the board. Because under current law, they are exposed to a catastrophic level of nursing home expenses and their only salvation is to spend down to poverty and Medicaid. So don't think that for a moment Medicare offers our seniors health care security. It doesn't. They just don't know it. So the idea that we could offer seniors catastrophic protection is something we do have an obligation to look at, and truthfully we know from the private sector that responsibility for first dollar coverage does reduce overall costs.

Now, not all seniors can afford a higher deductible. We have an obligation to look at that, just like we have always looked at the ability of poor seniors to participate in Medicare and we currently cover all the deductibles, all the premiums, all the costs for a lot of low income seniors. But for us as a Committee not to be even willing to look at and entertain the thought that with a higher deductible we might be able to provide a level of protection that has never been offered under Medicare and that in modern medicine and in modern life is becoming more than more essential would be irresponsible. Whether we do this through an option and how we move there would be irresponsible.

I don't know how much we can do this year, but I thank you for putting on the table a broader vision of health security for seniors and a bigger view of prevention. Because if we don't get there, to just say to seniors that the old program is what you should love and cherish is a totally inadequate response, and the problem isn't just prescription drugs.

So I look forward to working with you and I hope every Member of either party or all three parties will keep an open mind as we go through this. We may not be able to do all this this year. But not to recognize that there is something bigger than the Democrats' prescription drug program or our prescription drug program would be a crime. And secondly, not to recognize that neither our prescription drug bill nor the Democrats' prescription drug bill provided one penny of relief for seniors for 2 years is also irrespon-

sible. So I have been talking with a lot of groups for 2 months about how we could do a discount card.

I am glad to see you using executive authority on behalf of all the seniors. The preceding administration used it to use unemployment compensation funds for hitherto unprecedented uses. So—and they didn't talk to us about that. So you know, I am just delighted that you put on the table that seniors can't wait for some relief and that we have got to—as important as our work is this year we have got to begin to look at 5 years, 10 years, 15 years, 20 years and the kind of health security America's seniors will need.

I am sorry to have used my questioning time for a statement. But in light of Mr. Stark's comments I just think it is imperative that we try to lay aside the partisan differences. The issues are simply too challenging, and there isn't anyone on this Committee who knows the answers. So I urge all of us to work together and to work with you, Mr. Secretary.

Secretary THOMPSON. Can I make a quick comment, Congresswoman Johnson? I couldn't agree with you more. This is going to require bipartisan support if we are going to do it. And it is a great opportunity for prescription drugs, for catastrophic coverage, and my first love, which is preventive health, really to look at this sincerely and come up with a comprehensive thing.

You mentioned something that really I would like to quickly address, and that is the delivery of health care in America. We have a delivery system that is straining. And I think it is imperative that we look at this on a bipartisan basis, especially trying to develop new technologies for the prescribing of drugs, for the interaction of drugs, for admissions into hospitals. So much is being done outside of the medical delivery system and should be incorporated into the medical delivery system that could improve it considerably. I would love to work with you on that.

Chairman THOMAS. The gentlewoman's time has expired. The gentleman from New York, Mr. Houghton, wish to inquire?

Mr. HOUGHTON. Thank you, Mr. Chairman. Mr. Secretary, as always, it is good to see you. We are lucky to have you, your experience and your vision, and we are honored to have you right here today.

I want to go from the macro issues to a more specific issue. That has to do with rural America. In rural areas like mine in New York we have had trouble at tracking the Medicare+Choice plans because reimbursement levels are so low. I guess the question I have got very, very specifically is are there things we can do different to make sure that the competitive system works better in areas with low populations?

Secretary THOMPSON. We certainly are looking at this very seriously, Congressman. We are looking at the possibilities coming up with some demonstration programs and trying to develop a combination of the fee for service and the Health Maintenance Organizations (HMOs) and trying to develop maybe a Preferred Provider Organization (PPO) or some other spinoff that would be able to allow these individuals to deliver the choices, but be able to make a profit at the same time. We are trying to develop many different ways to simplify the forms, the rules and the regulations that

seems to be a tremendous burden on the Medicare+Choice programs, and so we are doing a lot of things internally.

I will be coming to you and to other Members with some of the suggestions that we are working on hopefully to prevent further erosion of those individuals getting out, but also allowing for new companies, new opportunities for more choices for people that live in your congressional district and a lot of people that live in my State of Wisconsin that have the same kind of difficulties that you are articulating here.

Mr. HOUGHTON. Thank you very much.

Chairman THOMAS. The gentleman from Pennsylvania, Mr. Coyne, wish to inquire?

Mr. COYNE. Thank you, Mr. Chairman. Mr. Secretary, as you know, Pennsylvania has a highly effective PACE program, Program of All-Inclusive Care for the Elderly, a prescription drug program for seniors over 65 and with low income.

Secretary THOMPSON. Yes.

Mr. COYNE. And one of the President's principles is that seniors ought to have the option of a subsidized prescription drug program benefit as part of modernized Medicare. That is his proposal. How do you see a subsidized prescription drug program through Medicare affecting State run programs like the one I pointed out, the PACE program in Pennsylvania?

Secretary THOMPSON. I don't see it having much of an impact per se, Congressman. I would look at it as a way in which it would allow the seniors better coverage. If the State of Pennsylvania doesn't change it, we will not in any way adversely impact on the PACE program in Pennsylvania. And so it would be an added—I don't know all the details of the PACE program, I am familiar with the generalities, but I would think that our—depending upon how we come out of Congress, but what the President is envisioning and what I am talking about today, this would be through the Medicare system and would be in addition, an additional resource for your senior citizens in Pennsylvania.

Mr. COYNE. So with a highly effective program like the PACE program you would see no negative effects?

Secretary THOMPSON. I do not, Congressman. I would see nothing but pluses.

Mr. COYNE. On another subject, is the Federal government willing to stand behind the drug discount cards? To what extent will the Federal government stand behind them and what sort of consumer protections or remedies will be available for the benefits and the discounts if the discounts are not delivered? How would you remedy anything that would?

Secretary THOMPSON. Congressman, we are going to have an annual review. We are going to have an annual review so that we would be able to find out if there are complaints and we could de-certify those providers. We are not putting any Federal dollars into it. We are giving the Good Housekeeping Seal of Approval for Medicare.

It is giving the block of 40 million people the opportunity to join a very vigorous robust PBM that will be able to go in and negotiate the best discounts possible. The pharmacist will enroll, we will be able to look and supervise them. If they are not measuring up, we

will be able to suspend that enrollment in the future. So there would be an annual review that will take into consideration any complaints, any problems that develop. That is where we are going to have the control.

And finally, and one thing that is being overlooked, is we are going to a year from now start publishing, start publishing the cost of the drugs and the lowest cost. So that your senior citizen in Pennsylvania will be able to look at this whole list of 100 drugs and find out the prescription and find out the other substitutes, the other generic drugs, and be able to pick which company is doing the best and then after 6 months could choose that company.

Mr. COYNE. How would you see that working inasmuch as the senior citizen or the recipient, the beneficiary would be able to get that information? How would that work?

Secretary THOMPSON. It is going to be on the Internet. We are going to have a 1-800 number, and we are going to have it staffed 24 hours a day, 7 days a week in the former HCFA office. I fine everybody in my office one buck, so I will have to pay myself. Now the Center for Medicare Services. And we are also providing and requiring the PBMs to do the same thing. So there is many avenues of information that will be given out for seniors to receive.

Mr. COYNE. Thank you. Thank you.

Chairman THOMAS. Thank the gentleman. The gentleman from California, Mr. Herger, wish to inquire?

Mr. HERGER. Thank you very much. It is very refreshing to have you with us, Mr. Secretary. President Bush's principles call for Medicare legislation to, quote, strengthen the program's long-term financial security. Given that, absent reform, combined Medicare spending will quadruple from 2.25 percent at growth domestic product today to 8.5 percent of gross domestic product, GDP, in 2075, changes are obviously needed. Can you tell us more about what the administration is recommending with regard to solvency?

Secretary THOMPSON. What we are hoping for is that we can work with you, Congressman, on a bipartisan basis and fill out the details of our principles and be able to bring in some cost efficiencies to make sure that the senior is going to be able to receive all of their benefits and the coverages. By competition and giving them the choice of staying in the same fee-for-service program that they now have or a new competitive program, we feel that we are going to be able to put this on financially secure ground that is going to be able to continue Medicare for your children and grandchildren the same as for mine.

Mr. HERGER. Well, I thank you very much, and I think what is so very important, and you certainly mentioned this earlier in your testimony, is that this challenge is not a Republican or a Democrat or—

Secretary THOMPSON. It isn't.

Mr. HERGER. Conservative or liberal challenge. These challenges, the only way we are going to meet them is by all of us working together to solve them. Obviously the longer we wait it becomes more difficult. So I do thank you and the administration for your efforts in this area.

Secretary THOMPSON. Thank you very much, Congressman. You are absolutely correct, we need to do it on a bipartisan basis. There

are several things that need to be improved. And working together in a bipartisan way, we could really strengthen Medicare, make it modern and give seniors the kind of coverage that they really are requiring and requesting. And that of course is catastrophic coverage. That is preventative coverage and it is prescription drug coverage, the three main things, and we can do it together and I think we would all feel very proud of ourselves if we were able to do that.

Mr. HERGER. Thank you. I yield back.

Chairman THOMAS. Thank the gentleman. The gentleman from Louisiana, Mr. McCreery, wish to inquire?

Mr. MCCREERY. Thank you, Mr. Chairman. And thank you, Mr. Secretary, for sharing your time with us today. I would like to elaborate a little on my colleague from California's line of questioning with respect to the budget and the impact that Medicare will have on future budgets in this country. He said accurately that it is predicted that Medicare will grow to 8.5 percent of our GDP if no changes are made by 2075. Just to put it in a little different perspective, CBO has testified before this Committee that if no changes are made in Medicare, Medicaid and Social Security, by 2075 those three programs will consume over 100 percent of the Federal budget if the Federal government continues to spend about 18, 19 percent of GDP. So you know, it is just incredible to me that this Congress has taken this long to join with some administration, any administration, and promote meaningful reform of not only Medicare but Medicaid and Social Security.

So I applaud the efforts of this administration to work with both sides of the aisle, Democrats and Republicans, on common sense reform that not only will preserve Medicare for the seniors of today and for me and you and the baby boom generation, but for future generations of Americans, both seniors and not so seniors.

I want to quote from the President's principles that you outlined. "When popular alternative plans are established, the government's contribution to any one Medicare plan should eventually be tied to the average cost of all Medicare plans, preventing any one plan from driving up the costs that all Americans must pay."

Can you expound upon that a little bit and tell us why it is important we move to a competitive model?

Secretary THOMPSON. Just like everything else. Competition and more choices allows for efficiencies to be developed. But I want to make sure—you know, everybody is going to say, well, that means they are going to do away with the fee-for-service program. Absolutely not. The President, that is his number one principle outside of prescription drug coverage, is that seniors will be able to continue their same fee-for-service program if they so desire. But the other programs that are going to have a lot of efficiencies built in are going to give seniors the same choices they had before they became seniors, the same choices that you have as a Congressman, the same choices I have and all the employees in the Department of Health and Human Services. When you have that kind of competition, that kind of choices, you can come up and develop the best health insurance program for yourself and your family, and that is what we want to do for seniors. We want to modernize it so that seniors can choose the best program, and if they can save money in the process, so be it, and they can pocket that. And if they want

to continue on with the same Medicare Program that they have now, that is fine.

But that is the beauty of what the President is pointing out. It gives them those choices and building in those efficiencies and that competition depending upon what the senior wants to do.

Mr. MCCRERY. In fact, Mr. Secretary, we know in other areas of our economy that competition not only provides more choices for our society but it promotes innovation, it promotes efficiency and it promotes better pricing for the consumer. And isn't that part of the administration's plan, to make sure that Medicare along with Social Security and Medicaid doesn't bust the budget, so to speak, in the out years, driving cash in the general budget from national defense, from highways, roads, environmental protection, courts, all the other things that the Federal Government must fund?

Secretary THOMPSON. That is very true, and that is why the President feels so strongly about the need to do it now. Everybody is talking about prescription drug benefits, both sides of the aisle, in fact all three political parties now, and we have an opportunity with that kind of focus to really do what is right and develop a strong Medicare system with choices, with additional benefits and with one deductible. That is going to pay the seniors so many more dividends and put this program on a financially secure footing that is going to last. And we have this opportunity, and I hope that we work together collectively and with bipartisanship to get this job done, and I thank you for your comments.

Mr. MCCRERY. I applaud your efforts.

Chairman THOMAS. The gentleman from Michigan, Mr. Levin, wish to inquire?

Mr. LEVIN. Thank you. Welcome, Mr. Secretary. I think your passion is laudable. I just want to say the more I hear and take at face value these passionate statements about preserving Medicare, about a prescription drug cost, about the need for prescription drugs, the more concerned I am how we are taking away the resources that would be needed. It is inconsistent in my judgment to talk with passion, and I believe it, about preserving Medicare and a new prescription drug program and then passing programs or proposals here that are going to obviate the availability of resources for either. And it is clear as we continue to pass bills through this Committee and pass bills through this Congress that we are taking away the resources to carry out the very objects about which you have, I think, deep and sincere passion.

But I don't want to put you on the spot on that. I want to instead ask you about some of these principles and what they mean. The first principle, one, all seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare. Does that mean in Medicare?

Secretary THOMPSON. Yes.

Mr. LEVIN. And that means a prescription drug benefit in Medicare for those who are on fee-for-service as well as other options?

Secretary THOMPSON. The details have not been worked out yet, Congressman, but it is our strong feeling that every American should have prescription drug benefits and the opportunity to be covered and those in low income should be subsidized to make sure that they have it.

Mr. LEVIN. But still you are saying as part of that really means in a modern Medicare system. So fee-for-service as part of that there would be a prescription drug benefit?

Secretary THOMPSON. There will be a fee-for-service with prescription drug benefits, absolutely.

Mr. LEVIN. Okay. Next in that regard I want to ask you, and leave a little time for discussion of preventative care, principle three is today's beneficiaries and those approaching retirement should have the option of keeping the traditional plan with no changes. It says those approaching retirement. Is the implication of that statement that the present traditional plan might not be available in a reformed Medicare for those who are not seniors today or not approaching retirement?

Secretary THOMPSON. That decision has not been made, Congressman.

Mr. LEVIN. It is left open by the way you have it worded.

Secretary THOMPSON. I know it. We are trying to put out the principles and we are trying to work with you on the details to come up with that. But the President wants to make sure that all seniors that are approaching that age and are in or under Medicare right now are going to be able to have their same program.

Mr. LEVIN. By that guaranty, that principle doesn't guarantee the traditional plan for those who are not in those two categories?

Secretary THOMPSON. We think that the new programs, Congressman, are going to be so much superior or that most seniors will want to take the best program for themselves.

Mr. LEVIN. But you are hedging.

Secretary THOMPSON. I don't want to hedge. I am just telling you that those decisions have not been made.

Mr. LEVIN. So the way the principle is stated, it does not assure the present conventional plan for those who are neither seniors nor approaching retirement. That is the way the principle is written?

Secretary THOMPSON. That is the way the principle is written. But it is also open-ended to allow for this Committee and Members of Congress to change and fill in the details. We don't want to be so prescriptive that we would come up here and have you criticize us, Congressman—I say that in a very laudatory way—that you would criticize us for not giving you the opportunity to have input. We want to be able to have the principles general enough so that you and all the Members will be able to have input so that we can develop a true bipartisan proposal.

Mr. LEVIN. I just want to emphasize when it is worded that way, it sends a clear message that there is an assurance for some but not for others. And I know my time is up. So I will ask you, if you would, to take another look at the letter that Mr. Foley and I sent you about preventive benefits, cholesterol and hypertension screening. The response we received to this area that you feel so deeply about was a very general response.

Secretary THOMPSON. Okay.

Mr. LEVIN. Maybe Mr. Foley, if he is here—

Secretary THOMPSON. Can you tell me when the letter was? I will take a look at it and call you next week about it because preventative health is something that we need to do in America.

Mr. LEVIN. It was March 8.

Chairman THOMAS. Thank the gentleman. The gentleman from Michigan, Mr. Camp, wish to inquire?

Mr. CAMP. Thank you, Mr. Chairman, and, Mr. Secretary, I appreciate you being here and I appreciate your testimony. I commend you for what you are trying to do. Your written testimony I believe is excellent, and the time is now, because this issue gets more difficult to resolve as time goes on, as you have mentioned. And over the years we have had a lot of battles on a lot of issues in this Congress, whether that is balancing the budget. Some said we do that and some said we couldn't balance the budget and have tax relief, some said we couldn't have welfare reform, that that would be a race to the bottom. And clearly your optimism and can-do attitude here in trying to positively move forward on an issue that is critical to our seniors I think is important, and I commend you for doing that.

I think in terms of the focus I am interested in is particularly this principle of a modernized Medicare Program which will help provide better coverage for seniors and help assist with preventative care and serious illness. Could you expand on the opportunities there in the President's reform proposal, please?

Secretary THOMPSON. We look at this system as a way to bring in some competition and choices.

Chairman THOMAS. If the Secretary would suspend for just one moment. There is a vote on. It is a vote on the rule on H.R. 7. The Chair intends to continue the hearing through the voting process. So if Members who don't anticipate being called rather quickly for questioning would like to go vote and come back, we will continue the hearing. Thank you.

Secretary THOMPSON. Thank you. And those choices we think are going to bring a lot of innovations, as you have indicated. We think that the Federal Employees Health Benefit Program is one that we would like to incorporate into the Medicare system. And as Blue Cross and Blue Shield is required under the law, in order to bid on the Federal Employees Benefit Program has to have seven programs in every county in America. And I would love to see the seniors in America to have seven choices of what could be the best program to be developed for that individual person, whether it be in Kentucky, whether it be in Florida, whether it be in New York or Wisconsin. And I think that is what we are really driving at. I think it would benefit. I think seniors would respond and say, you know, I had those choices before I became 65 and I will have those choices again. I really appreciate that opportunity.

Mr. CAMP. I also think in the prescription drug area as you testified, 27 percent of seniors don't have prescription drug coverage. There has been pretty broad consensus in the Congress, I would say an overwhelming majority of Representatives and Senators feel that a modernized Medicare Program must have a prescription drug component in it, and I think that is a critical part. I commend you for having that in your plan as well. And even though I appreciate your comments, particularly coming from a rural area in Michigan, the idea of having the choices available to seniors in every county, and in my county I am able to get assistance through the Federal health benefit plan and able to get the care for myself

and my family, I think if we could do that for seniors it would be a very positive step forward.

So I thank you for your testimony and look forward to working with you on this. Thank you.

Chairman THOMAS. Thank you. Does the gentleman from Minnesota, Mr. Ramstad, wish to inquire?

Mr. RAMSTAD. Thank you, Mr. Chairman. Mr. Secretary, always good to see my neighbor from Wisconsin. I appreciate the good work you are doing. I want to thank you and the President for providing Congress with an excellent framework for reforming Medicare, including the prescription drug benefit that we know is needed.

As you know, Mr. Secretary, I represent Minnesota's medical alley, home to some of the best medical technology companies in the world. I have been touting the significant quality and cost saving benefits of technology for years, was very encouraged by the President's emphasis on strengthening Medicare, as he said, to ensure the new generation of medical technology is available to seniors, which I think is absolutely critical.

But I must say, Mr. Secretary, I am concerned that the CMS—I have to quit saying HCFA—CMS, the Center for Medicare and Medicaid Services, concerned that that there is a proposal by CMS to reduce the reimbursement for international classification of diseases (ICDs) in the inpatient, ICDs being the implantable cardiovascular defibrillators like the one that was recently implanted in Vice President Cheney which was, as you know, made in Minnesota in fact.

I believe our seniors deserve the same access to this life saving technology as the Vice President received. And recently two of my colleagues Ms. Dunn and Mr. Hayworth joined me in asking CMS to delay this reduction in reimbursement for ICDs in the inpatient setting because they are already notoriously underreimbursed. And I am sure you will agree that reducing the reimbursement for these life saving devices will limit patient access, and that is not the message that either Congress or the administration would want to send to the seniors of America.

Can you tell me today if CMS will delay this change?

Secretary THOMPSON. I can't tell you without looking at it, Congressman. But I certainly can tell you that I will look at it and get back to you the beginning of next week. And I can tell you that I will lean heavily on them and I am fairly confident that we will come up with the right answer. But I would like to point out what you are saying is exactly what needs to be done. We have got to get more new technology into the health care system. This is something that is going to drive down costs, impact patient safety and quality of care, and it is going to be in the lines of prevention that is important.

The President believes this. I am passionate about it, as you are, and I thank you so very much for bringing it up, because it is something that we badly need. And if CMS is making a mistake on this I am confident we will change it.

[The following was subsequently received:]

In order to ensure that Medicare pays appropriately for defibrillator implants, CMS is not delaying this change. I agree that Medicare beneficiaries deserve access

to life saving technology, and I also appreciate your concerns, as well as those of other Members, that Medicare pays appropriately for the implantation of defibrillator in an inpatient hospital setting. CMS reviewed the most recent data available on the relative costs and charges of services performed during an inpatient hospital stay, and these data indicated that the cost of implanting a defibrillator was lower than the cost of other cardiac procedures in Diagnoses Related Groups (DRGs) 104 and 105. As a result, CMS separated defibrillator implant cases from other cases involving cardiac procedures in those DRGs. This lowers payment rates for defibrillaor implant cases, and increases payment for other cardiac procedures in DRGs 104 and 105, effective October 1, 2001. CMS will continue to examine the costs of cardiac procedures and make future adjustments in order to ensure that we continue to pay appropriately for these services.

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Mr. RAMSTAD. I certainly appreciate that can-do spirit and your commitment to get back to us on that in such speedy fashion. It would be a horrible message to send that the Vice President receives this and seniors don't have the same access to that life saving technology. And Medicare seniors, as you agree, do deserve the same access to technology as the rest of us, as those of us who are nonseniors, although I think technically I probably qualify now for that status.

I want to ask you also about the overarching problem with respect to managed care reimbursement and the arcane and archaic and unconscionable adjusted average per capita cost (AAPCC) formula. I have raised this issue with you before, as you know. I believe the President's principles of long-term financial security for Medicare and high quality health care for all seniors are absolutely vital. But I don't think they can become a reality until we reform the highly flawed reimbursement formula for Medicare managed care. And you know we made some improvements at least in statute, but States like mine, Minnesota, yours, Wisconsin, Mr. Nussle's, Iowa, and so many States that deliver high quality health care but have done it in a cost efficient manner are penalized by this arcane, ridiculous formula that is counterproductive, that penalizes frivolity and waste instead of rewarding States that have delivered high quality health care in a cost effective way.

So I look forward to working with you and my colleagues to reform the reimbursement formula. I think we have to scrap the current formula so that seniors in all States across America have access to quality cost effective care. I assume I can count on your commitment to work to bring equity to Medicare reimbursement.

Secretary THOMPSON. Congressman, all I can tell you is you sound like I would be spouting off when I was Governor about those formulas.

Mr. RAMSTAD. Keep sounding off as Secretary.

Secretary THOMPSON. I know exactly what you are talking about. I have testified in my former life on that particular subject, and we are looking at it and I welcome your assistance and your cooperation, and I am confident we can improve it.

Mr. RAMSTAD. The final statement, Mr. Chairman, if we can do as you suggest, take off the Republican hats, take off our Democrat hats, and even our Independent hats, work in a bipartisan, pragmatic, common sense way, we can get it done this year. We can; don't you agree?

Secretary THOMPSON. I really believe we can and I think we should.

Mr. RAMSTAD. Thank you.

Chairman THOMAS. Mr. Secretary, we have been informed from the floor we have two votes consecutively, which means it is going to be a while for us to come back. We probably will be able to resume at 12:15. Does your schedule permit you to wait and then perhaps entertain additional questions from Members?

Secretary THOMPSON. Chairman, I have never said no to the Ways and Means Committee, even though it will be difficult.

Chairman THOMAS. I appreciate that. We are going to try to move through. And therefore, rather than recess at this time I will recognize the gentlewoman from Connecticut and she can proceed, and if any Members are willing to come back we might be able to loop them through. But we are under 5 minutes on this vote. Then there will be another vote following.

I thank the Secretary for his indulgence. The gentlewoman from Connecticut.

Mrs. JOHNSON of Connecticut [presiding]. I thank the Chairman for his courtesy. I voted early so we could try to keep this going throughout the votes, but because of the consecutive votes we can't do that. But having already voted and having used my earlier time to express my opinion on a number of issues, I do want to just put on the record the fact that this issue, this possibility of merging the A and B deductibles, needs to be looked at also from the point of view of what would be the consequences of merging the A and B systems, because as we look at regulatory reform we are beginning to run into the snaky consequences of our past actions. And one of our past actions was to move part A costs to part B. So now you have, for instance, home health services billed under both programs and it is very complicated for the providers to know whether they are billing under A or B, and this will be a bigger and bigger problem.

So what I would like to ask you is if would you give us some help in looking at what would be the provider impact of merging those two systems? What would be the administrative savings of merging those two systems? Because Mr. Stark's concern with cost is genuine and where the resources are going to come from, and of course in the past that has been a big reason of why we haven't done a better job of preventative health benefits.

But when you look at the big picture, all the separate systems of the A/B services and the administrative structure that imposes to me makes little sense. But we need a lot more than just that kind of intuitive response. Would you be willing to commit the resources to look at what the implications for both government accountability and provider capability are of merging A and B administratively?

Secretary THOMPSON. Congresswoman Johnson, absolutely. It needs to be done. In fact, we are already working on that, and we will continue to work on it. It needs to be looked at seriously. The President believes it is the right thing to do, as I do. And we will be looking at the pros and the cons and how we could integrate them together, and we will be working with you and with other individuals on this Committee to come up with the best plan.

Mrs. JOHNSON of Connecticut. It is important to remember that no business runs itself this way, separates out one portion from another. I see we have been joined by my colleague, Mr. Ryan. I will recognize him.

Mr. RYAN. Thank you, Chairwoman. Secretary Thompson, it is great to see you here again. I am always sorry that you didn't get the Wisconsin hospitality here in some of the questioning. This bitter partisanship is no way to solve a problem as large as what we are facing. So I hope that in the future you will be met with good bipartisan dialogue.

I think it is important for people who are watching the debate to know that if we don't add any benefit to Medicare, it is still going to go bankrupt. As you showed in your charts, the baby boomers are coming. And when we nearly double the amount of seniors we have in this country, it is going to put a lot of pressure on the existing program. It will eventually become insolvent in a number of decades, according to the trustees. In about 2016—correct me if my number is not right—we are not going to have enough FICA taxes to cover existing benefits. So it seems like you have an incredible challenge facing you, which is, one, the benefit structure is not modern and we are basically giving people 1965 health care in the year 2001 with respect to Medicare.

In Wisconsin, where we come from, the mere fact that people have to buy these costly supplementals just to fill in all the gaps that Medicare doesn't currently cover, and that doesn't even include prescription drugs, is testament to the fact that it is an unmodern program, no longer comprehensive, and at the same time we are trying to modernize and improve the benefit structure like prescription drugs and other important principles you have articulated, we have this inventory problem. So we have to fix the solvency, get more money in the system through price competition, and modernize the benefits, a real conflicting agenda.

So you really have an incredible challenge. I appreciate these principles. I just wanted to ask you to clarify something because those who detract against comprehensive reform often try to say you are going to lose what have you right now. You are not going to have the chance of keeping what you have and you are going to go on this roller coaster. They often say privatization, but privatization would mean no government intervention, you are on your own, and that is clearly not the case.

Could you explain just exactly what kind of choices people will face under the principles you have outlined?

Secretary THOMPSON. Absolutely. First off, let me thank you, Congressman Ryan, for your hospitality, your friendliness and your job that you are doing for Wisconsin. I appreciate that as a person that has watched you for several years now, and I am always impressed.

Second, in regards to your question, people love to have choices. People love, you know, to be able to pick and choose. And what we are trying to do is we are trying to set up a system to say to that senior citizen, who some people like to scare, that they are going to somehow lose something, they are not going to lose, they are going to get better. It is going to be an improved system. And if they want the old system, they can have it. But the new system

is going to provide coverage for prescription drugs. It is going to provide for catastrophic diseases which Medicare doesn't provide for. It is going to expand preventative coverage. So that a senior can go and decide for himself or herself what is the best program for them, and it may be better nutrition. It may be more expanded drug coverage or it may be a larger deductible.

But they will have that choice. But to really allay any fears that that senior has, they can maintain their existing program. But we think most seniors when they compare and say this is my existing program but this is better, seniors are going to take what is better for them, and that is what we want. We want to give them the same choices that you have, Congressman, the same choices that I have. And we can pick and choose. And let's set it really out there. Seniors are very bright people. They know what is going to be the best for them. Let's give them the opportunity to have an expanded benefit program and let them decide which is the best for them.

Mr. RYAN. That is what is interesting is because we as Members of Congress, you as a Federal Government employee, we have a book we get where we have all of these options and choices of which plans we want, which are comprehensive. We simply want to give seniors that same choice, and in addition to keeping what they already have. It kind of goes with the old metaphor, in Elroy, Wisconsin, when you were growing up, you may have had just one general store that everyone had to go to for all their goods.

Secretary THOMPSON. That was the Thompson Grocery Store.

Mr. RYAN. That is right. I thought you were. You were monopolists in Elroy. Maybe your forefathers were. You have one place to do your shopping for your health care benefits, you are beholden to a monopoly. Right now we have a Federal Government monopoly for health care for seniors in most places in America. What we are trying to do here is give seniors more choices so that the individual, the consumer, the senior citizen is the center of the health care universe, not the government, and so that people compete for their business and as people compete for seniors' businesses and try and win over their support through their personal choice, we then save money. We have more competition, which roots up inefficiencies. That is how it seems like we can get to the twin almost sometimes seeming exclusive goals of saving Medicare for the next generation and the generation after and improving people's benefits.

So when we see some of this partisanship that we have here, I am sorry you have to come and experience this but if we can push that aside and work as Democrats and Republicans together with your leadership, and you have shown in Wisconsin that you can do that, you can bring Republicans and Democrats together. I am just excited about you being here leading this effort. I am excited about your passion. Now the Nation can see the passion and the abilities that you have shown for us here in Wisconsin that you can bring Democrats and Republicans together to save this program. I am just really excited to get going on this, and I just thank you for what you are doing. I sure hope we can do this this year.

Secretary THOMPSON. Congressman, you are so correct. I thank you for your very generous comments and I appreciate them very much. But everybody in America knows that we have to have pre-

scription drug coverage for seniors, and everybody wants to do that. I haven't found anybody in Washington that has come up to me and said, Secretary, we don't want to have seniors have prescription drugs. I have not met that first person. Everybody believes that, Democrats, Republicans or Independents. And that gives us the catalyst, the opportunity that doesn't come around very often in government, to work together like we did in 1965 when the first program was set up to really modernize, strengthen, expand, give people choices and give them the opportunity to have the best Medicare system for everyone and be able to allow it to be able to be passed down to their children and grandchildren.

As the President pointed out, one of the best cars was the 1965 Mustang but it didn't have power brakes, it didn't have power steering. But it was a great car. Medicare was a great health system back in 1965. But in 35 years it has gotten old. It needs some modernization. It needs some opportunities. That is what we can do together. I think if we did it together, all parties, all individuals would look back on this and say it was the right thing to do. We stood up, we were counted and we made the tough choices, but look what we were able to accomplish.

Mr. RYAN. Thank you, Mr. Secretary. I also want to thank you for acting early, because if you look at the bills that we are moving through Congress last session, the prescription drug benefit that we talked about, Republicans and Democrats didn't kick in for a couple of years. Your early action in trying to administer a partial benefit in prescription savings right now is the first time to my knowledge that a Cabinet Secretary has been able to bring us some solutions and some ideas right away so that we can bring in and extend some relief to seniors today, not 2 or 3 years from now.

So we do have another vote. I notice that most of our Committee Members aren't back yet, so I think the Committee will stand in recess, as directed by the Chairman, until the vote concludes. Thank you.

Secretary THOMPSON. Thank you, Congressman.

[Recess.]

Mr. RAMSTAD [presiding]. The hearing will come to order. The Secretary will be back momentarily. Chairman Thomas is delayed on the House floor in connection with the pending legislation, and so we will resume the questions of the gentleman—welcome back, Mr. Secretary. We will resume the questions with the gentleman from Maryland.

Mr. CARDIN. Thank you, Mr. Chairman. And Mr. Secretary it is a pleasure to have you before our Committee. And I very much appreciate your comments on preventive health care because I agree with you completely. Mr. Thomas and I, in 1997, co-authored the Preventive Health Care Package, which you referred to as, I think, visionary, and we agree with you. Will you let me just alert you to some problems that we are having.

Part of that 1997 package included, for example, colorectal screening, and we're finding that because of the problem in getting reimbursement for the office visit, which is necessary before you have the colonoscopy, that very few seniors are, in fact, taking advantage of this service because the reimbursement structure has

not kept up with the technology, and that is the one of the issues I know that you have mentioned.

So let me just urge you to not only look at ways of expanding preventive health care services, but also at those coverage services that are not being fully implemented today because of administrative problems within the agency. I would urge you to look at that and try to find ways that we can make these services available to greater numbers of beneficiaries.

Secretary THOMPSON. Congressman, if I could, I would suggest—and I appreciate that. I would love to have you write me or call me with suggestions, because you believe like I do, that preventative health care is the way to go in America. And we need to do more of it, and we need to get our reimbursement formula set up so that preventative health is really considered first. And any suggestions you can have I would love to get them. I love new ideas, and if you have got a way to do it, I would solicit your information as—

Mr. CARDIN. I promise you I will take you up on your offer and I will work with you on this.

Secretary THOMPSON. I would appreciate it.

Mr. CARDIN. Let me mention another area of health reform that you did not mention in your statement, and I would encourage you to take a look at it, and that is graduate medical education and the way that we reimburse for graduate medical education. We have the best quality training facilities in the world, and the way that we currently fund graduate medical education puts a real burden on the Medicare system because Medicare pays the lion's share of the cost of graduate medical education, even though the trained medical personnel are used by all Americans regardless of age.

I filed what's known as the "All-Payer Graduate Medical Education Act." It created a structure through which all of the users of our health care system contribute to the cost of graduate medical education. It is supported by the academic centers. The academic centers are under tremendous strain right now to continue their traditional mission. They receive some reimbursement for the cost of training, but they also usually treat the largest amount of uncompensated care patients and the most difficult patients. And I believe that as part of Medicare reform we need to look at a fair way to ensure that graduate medical education is adequately funded in this country without unduly burdening the Medicare system. I really hope that we can work together on that issue as well.

Secretary THOMPSON. I thank you for it. I mean, these are the kinds of ideas that we need to sit down and discuss in a bipartisan fashion and come up with solutions and I—all I can say is thank you for offering it, and I will take you up on it and I want to work with you.

Mr. CARDIN. Let me lastly mention the EMTALA, the Emergency Medical Treatment and Active Labor Act, recommendations that you mentioned in your testimony, specifically about the hospitals and the definition of a hospital for treating emergency patients. We are making progress in this area. I think the Patients' Bill of Rights will clarify access to emergency care requirements within our HMOs. But it is interesting, if you take a look at some of the problems that hospitals are facing today, one of the reasons that

they are under tremendous financial pressure is the large number of uncompensated care that they provide. In addition, problems with HMO reimbursement have also had an impact on the strength of the margins of our hospitals.

So once again, it comes back to an issue in which Medicare is really paying the lion's share of costs of uncompensated care costs. It is another area that we need to take a look at reforming, particularly as to how we reimburse the HMOs. If they are going to use the hospitals that have large amounts of uncompensated care, that is one thing, because then they are helping to pay for the cost. But if they are not and they are still getting the reimbursement under Medicare as if they are using them, that is creating inequity within the system.

So this is another area in which I just urge that we review how we pay for uncompensated care within the Medicare system to make sure that it is fair for all the users of the system. Those are some of the issues in Medicare reform that cry out for change and that would make the system far more cost effective.

Secretary THOMPSON. It certainly would Congressman Cardin. And as you know, the EMTLA, the law, the way it is set up, as I understand it, is that if a hospital purchased a physician clinic, or has a diagnostic building somewhere outside of the environs of the hospital, they have to provide for some kind of emergency care because it is part of the hospital. And so it is very expensive, very time consuming.

And what we are trying to do, which I announced today, is we are redefining what a hospital is so that we are redefining what an emergency room is that would be able to take care and solve that particular problem. But the rest of the ideas that you have, let us work together and let us see if we can't do what is right in order to make the administration, as well as the delivery of health care much better.

Mr. CARDIN. Thank you, Mr. Secretary. I will follow up with letters.

Secretary THOMPSON. Please. Thank you I encourage you to do so.

Mr. RAMSTAD. The gentleman's time has expired.

Mr. Secretary, just let me say in response to your appearance here today, to say that you are a breath of fresh air in this town is a gross understatement, and we certainly appreciate what you just said and your willingness to work in a bipartisan way on these problems on reforming medication is very refreshing indeed.

Next questioning will be by the gentlewoman from the State of Washington, Ms. Dunn.

Ms. DUNN. Thank you very much, Mr. Chairman, and welcome Mr. Secretary. It is good to have you before us again, and we appreciate your being able to carve out enough time so that we can all go through the questioning. I want to just make comment on a couple of things we have already heard about. I am relieved, as I hear you talk about how we are going to communicate with seniors after we put this Medicare reform package together. I think there is a lot of fear among folks who may not be in the position of easily being able to change their ways, and so to take that fear off, to tell them they can stay involved in traditional Medicare I

think is helpful. But also the 1-800 number and some of the other ways that we will communicate with them what their choices are and help them out in deciding what is best for them, I think that is very important.

And I also want to say to you that I am refreshed by the administrative action you have already taken. I want to ask you a question on it, but the drug discount card, I think, is going to be wonderful. And we have to carve this into a position so that we are not putting the onus on prescription drug people or pharmacy people alone; that it is a fair burden. But to provide something like that to seniors administratively that could have been done over the last many years and wasn't, I think that is just great.

I wanted to ask you to comment on the waivers situation, because what I am hearing is that under your leadership, we have been able to do a lot in allowing States to test out, and I think that is a very good way to experiment and decide how things are done well. I wonder if you would comment on that.

Secretary THOMPSON. You mentioned three subjects I really am happy about. What we are trying to do first is information. We are trying to hold hearings, just like townhall meetings that you hold in your State and in your congressional district through the Centers for Medicare Services, not only with beneficiaries, but also with providers, so that they understand the new rules, we can get the feedback and we can work with them in a much more cooperative fashion. And I told all the people at Centers for Medicare Services, instead of trying to find a way to say no, try to find a way to say yes. If you can't say yes, come up with a denial, but explain it so that people understand that if they do it a different way they can get it. That is number one.

Number two, in regards to a 1-800 number, we are doing that, but we are also going to put out a \$35 million publicity operation this fall to explain to the seniors, you know, what we are offering, to be able to give them an idea all the Medicare—we are going to have a 1-800 number and it is going to be staffed 24 hours a day, 7 days a week. So your questions can be asked. And we think that is going to be very helpful. We don't want—you know, it has been—in the past you know you can demagogue this issue and you can scare seniors. What we want to do is give seniors the opportunity to know what is available, and that they are—they are very smart people. They have an opportunity to pick and choose what is best for them, and that is what we are trying to do.

In regards to the prescription drug card, we don't want to take it out on the pharmacist. We want to be able to go to the pharmaceutical companies and with the power of 40 million subscribers, you are going to be able to get a good discount from the pharmaceutical companies and be able to pass that on through the pharmacists to the individual senior citizen. And that is what the program is all about.

Ms. DUNN. Could you, Mr. Secretary, talk about waivers for a moment?

Secretary THOMPSON. Waivers, when I started, we were about—we had about 632 waivers and amendments to State plans that were behind. And I made a dedicated decision that we were going to clean up the backlog and make prompt decisions. And I am

happy to be able to report to you, Congresswoman Dunn, that as of September 1st, we should be completely cleaned up of all the backlog and be able to proceed and be able to make responses to State governments within 90 days, so that they can move forward.

I come from that background as you know, and I want to be able to give States the flexibility. Your State of Washington, you know, your Governor, Gary Locke, has got some innovative ideas. They should be able to develop better programs. Let us see what works and then let us take what is best from Washington and export it to other States and other governmental districts and improve the health care system. And that is why it is important for us to move rapidly and make quick decisions and decisions that require neutrality as far as finances, but flexibility to give the States the opportunity to move forward with new ideas.

Ms. DUNN. I appreciate that a lot. I think that is amazing because what we have heard is some of those waivers have been hanging around since the mid 1980s. And for you, without your full cadre of appointed positions completed yet, to be able to move so quickly, I think is really a great first impression for some of us.

I want to just follow up with a sort of a question that you may not even want to handle, but some of us on this Committee also do a lot of tax relief legislation. In 1993 the budget increased the base of—for seniors of what can be taxed in their Social Security income from 50 percent to 85 percent. Seniors now are paying taxes on 85 percent of their Social Security income. Those dollars were taken by the then-President and put into the Medicare fund so it would be very hard for us to get those dollars back to reduce that rate again.

Is there any way you could see tying a reduction in the basis of Social Security funds that are taxed to Medicare as we go through this process? Is that a long shot or is that something we could think about doing?

Secretary THOMPSON. I haven't looked at it. I don't want to make a snap decision on it. But I would be more than happy to review it and get back to you if that would be permissible.

Ms. DUNN. It was an idea that came up in the last few days and I think it might be something we will want to do. It may be too expensive, but we really want to get those dollars that are taxed for seniors living on Social Security down as quickly as we can. Thanks, Mr. Secretary.

Secretary THOMPSON. Thank you so much.

Mr. RAMSTAD. The gentlewoman's time has expired. The gentleman from Washington State, the good Dr. McDermott.

Mr. MCDERMOTT. Thank you. Mr. Secretary, there has been a lot of talk about prevention. The President talked about covering physical examinations, periodic physical examinations, and the intention—is your intention to put that into the bill? Does he support covering periodical physicals?

Secretary THOMPSON. Congressman McDermott, the President feels very strongly on prevention as I do, as you do. And we have not delineated what should be included, what should not be included at this point in time. We want to work with you on the details. And so I would say from my point of view, yes, it would more than likely, and should be included, but it is going to have to be

something that we work together on what can be included and what can't be.

Mr. MCDERMOTT. I have got a bill.

Secretary THOMPSON. I know you do. But I don't want to get into the—

Mr. MCDERMOTT. All right. Let me just say why I put the bill in. We spend a lot of time here trying to decide what new technology, we ratchet up all—the latest thing in colonoscopy, the latest thing in mammograms, and we want to spend millions of dollars, but we never do an evaluation as to whether it makes sense to do some of those things. We let the specialties drive up some of these things without doing what managed care does, which is a gatekeeper who says this is somebody who really ought to think about doing this, on more than doing that, and I think that that is why a routine physical examination is something that would not cost more, and it probably would actually save some money because you wouldn't do some of the higher price tests. And that is why I include it. Let me go to the second thing.

Secretary THOMPSON. Can I respond quickly?

Mr. MCDERMOTT. Sure.

Secretary THOMPSON. I think you are absolutely correct, Congressman. And I think you are going in the right direction. But I would like to quickly point out that I believe, and this is my own personal opinion, that we are doing a woefully inadequate job in the delivery of health care in not using the new technology.

On the physical examination I agree with you, but I have to disagree that I think there is so much more that could be done for patients' safety, quality of health care, improved efficiency, by using new and better technology, and a much more reduced paper situation and admissions, on prescribing drugs and on the administering of the drugs.

Mr. MCDERMOTT. I don't disagree with that. Now, the next question is, you have talked about technological breakthroughs, and you know where I am going. If one of the major issues or a number of the major issues you deal with in Medicare are things like Alzheimer's disease and Parkinson's, and we can go right down the list. It seems to me that the issue of stem cell research has had a report from every single major scientific organization in this country, including yesterday the NIH, National Institutes of Health, all saying that we ought to pursue embryonic stem cell research.

Now, I have been watching this issue, first told it was going to be decided in June and then it was going to be in July, and now we are to the end of August. And I, you know, you and I have been in this business long enough to know when the fix is in. It is really hard to believe that anybody is going to make a decision then. What are you going to know? What is the President going to know at the end of August, except for the fact that he will have visited with the Pope? What other issue will he have gotten any information on this issue that is not already out there and understood by a hundred of his advisers? What is the delay really about unless it is just plain politics?

Secretary THOMPSON. It is not. And I want to allay your fear of that, Congressman. I have been with the President and as you know, I have been very much involved in this subject. And—

Mr. MCDERMOTT. And we are supportive of it.

Secretary THOMPSON. And I requested NIH to make the report. And NIH responded. And I want to tell you, I have been with the President. This president is working harder on this issue, looking at the pros and the cons. He has some real strong feelings, and he wants to make sure when he makes the decision that it is the right decision. And he is not looking at politics at all in regard to this. I know you may find that hard to believe.

But I have seen this individual. He is very engaged, more engaged, listening to more people on this subject, and I am one of those individuals that have given him information, and I know he is reading it. I know he is discussing it. I know he is meeting with people. And I am confident he is going to make a decision and it is going to be in the relatively near future.

Mr. MCDERMOTT. Well, let me just say, in your communications with him, I hope that you will take this message to him. There are two things that are going to happen. One of them happened the other day and is going to continue and I think escalate. That is leading scientists from USC, San Francisco said good-bye, I am not going to waste my time in the United States. I am going to Cambridge where they have been doing this for years. They have a commission over there that judges the ethical issues. They are way down the road ahead of us. So that is going to be one of the things that happens continually.

The second thing that is clearly happening from recent newspaper reports is the research is going on out there. And unless you think the Congress is going to pass a bill that says no one can do this research, it is going to go on out there, and the government is not going to have a single thing to say about it. And I think that the President has an opportunity, if he has some strong feelings about it, to get into it in a way that cuts off this sort of—people will be cloning whatever they want over in Virginia, or in Pennsylvania or wherever. It is going to go on because the search for knowledge is not going to be stopped by one administration here or there.

It is a question of what role we are going to play in it in terms of whether we further it and try and direct it or put any kind of restraints on it. The longer he delays, the more these other paths will be taken. And I think that I can't emphasize strongly enough, it was not a good decision to have stopped the process. But since he has done it, he would be a lot better off politically to get out of it as quick as possible. There is nothing to lose. He has nothing to lose at this point.

Secretary THOMPSON. Thank you, Congressman McDermott.

Mr. RAMSTAD. The gentleman's time has expired. We were just informed that the Secretary has to leave shortly after 1:00, so we are going to have to move right along. I just want to add one comment. I just hope the President is listening to you and Nancy Reagan on stem cell research.

The gentleman from Georgia, Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman. Thank you Mr. Secretary. You know you hear a lot of criticism in this town about HMOs. I compare the Medicare Program, the Medicare insurance program is just a giant government-run HMO. You have pointed out a lot of the inefficiencies of it. A lot of it, I think, comes from the fact that the Board of Directors of the Medicare insurance, the Members of Congress, and you have seen some of the disagreements that we have here today, and some of the expressions of those Members of the Board of Directors. I plan to share your information on the principles of the President's 8 points, principles, with my seniors in the district that I represent, and also with the providers. I think you have some very good advice there for us to do.

My question kind of goes back to the Medicare prescription discount card. Could you kind of walk us through exactly how the new discount card proposal will yield a real savings to the Medicare beneficiaries and how do these cards differ from what is currently on the market? And what level of savings can our beneficiaries expect to receive? How much of those savings will come from the pharmaceutical manufacturers, versus the pharmacists? I do think there needs to be a sharing in this and I believe you have expressed that earlier. But I would like to have that reassurance and also a walk-through. I would like to say this about our neighborhood pharmacists. I think we have to keep them in mind through this whole process.

The neighborhood pharmacist is probably one of the most trusted individuals within the community. They probably answer more questions when it comes to the prescription drug than the prescriber of the prescription. And I do think too that they would probably be a very good outlet for CMS when it comes to putting out the information for our seniors because of the trust that our seniors do have with our local neighborhood pharmacists. So if you could kind of walk us through and how one versus the other and how the savings will occur.

Secretary THOMPSON. I will certainly try, Congressman Collins. And let me point out that the individuals that pay the highest amount for drugs are the uninsured, especially the uninsured senior, the 27 percent, because they walk into the pharmacist and they have nobody to run interference, to do their purchasing for them and to get the best price. So they are the ones that are paying the highest price. And usually, they are the ones that are the least able to afford it. And so the prescription drug card is set up so that all of these seniors, especially the 27 percent, have got the buying power of a State government, of an HMO, of an insurance company, to be able to get the best price for that individual. So it is going to be the biggest help to the 27 percent of the seniors that don't have any coverage whatsoever.

Now, we set it up so that we wouldn't have one company; we are going to have possibly 10 to 12 companies that are going to meet the requirements and be able to bid, to be able to use the seal from CMS, the seal of good approval. And this gives those PBMs the opportunity to go to a pharmacist, but more than that, go to a pharmaceutical company and get the best price they possibly can. And when you have the purchasing power of the potential 40 million Americans, 12.4 percent of the population that purchases one third

of the drugs in America, you can well imagine that you are going to have tremendous purchasing power and be able to get the best price from the pharmaceutical companies.

So I believe that those PBMs will be able to get the biggest discounts from the pharmaceutical companies. In regards to pharmacists, they are going to have to voluntarily enroll. It is not a mandatory program. But in order to become a licensed PBM, they have to say to CMS that they are going to be able to provide coverage for all seniors that they represent. And that means in your community, Congressman Collins, as well as my community, if we have subscribers, that means they are going to have to go and enroll those pharmacists. And those pharmacists are going to want, I believe, to be enrolled because it is going to increase their traffic considerably and, therefore, it should be a benefit to the local pharmacist for the added business that it is going to bring in.

Now, will their prices be lower? Yes. But will they increase businesses? Yes. And so I, for one, you know, come from a rural area, and the pharmacists are very important and we don't want—and we take into consideration. That is why this program, I think, is one of those win-win programs. It is certainly a win for the seniors. It is certainly going to be, I believe, a win for the pharmacists. And it is certainly going to be a win for your constituents, and that is why we think it is a very viable program, and we think that once this gets up and running, it is going to give probably somewhere in the neighborhood of 20- to 25-percent reduction.

Now, is that—that is a wonderful first step. But it is only the first step. And that is why we have got to go the next bigger step and restructure and give a prescription benefit to every senior in America.

Mr. RAMSTAD. The gentleman's time has expired.

Mr. COLLINS. Thank you, Mr. Secretary. And I am very encouraged by the fact that you all are moving the ball forward. Thank you very much.

Mr. RAMSTAD. The gentleman from Ohio, Mr. Portman.

Mr. PORTMAN. Thank you, Mr. Chairman. And Governor, thank you very much for being here again and providing us with refreshing testimony. I want to thank you particularly for your personal commitment to reform at what used to be known as HCFA and now known as CMS, and for your choice of Tom Scully, who I think is a reformer and will do a good job there. The fact that you moved your office out there and lived for several days with those good folks and tried to figure out some of their problems is very impressive, given all that is happening here in Washington and all you are involved in. You have got a lot of work to do, and I applaud you for what you are doing administratively for starters, but also looking, of course, at the longer term problems and coming up with these principles.

I would encourage you to be very aggressive within the administration and up here on the Hill to push us on Medicare reform. It is a tough issue. It involves some difficult political decisions, but nothing is more important over the next couple of years as we look at these very difficult fiscal realities we face. You mentioned the fact that we will have many more folks who will be retired as compared to those working. That is true with regard to both Social Se-

curity and Medicare. The Medicare number is even more troublesome and the potential cost increase is even more dramatic, which could have a terrible effect, of course, on the seniors I represent and around the country. So thank you. Keep pushing us and keep pushing the administration.

With regard to the card, some of the questions I had have already been answered. As you probably know, Governor Taft has proposed a similar program in Ohio. I think it has tremendous benefit to help seniors who find it so difficult to meet their prescription drug needs because of the high cost. And I understand what you are saying with regard to higher volume and potentially lower margins. I just want to echo the comments that have been made by my colleagues, Ms. Dunn and Mr. Collins, that you seem to be in agreement with, which is that our neighborhood pharmacies, many of which were family owned, do have a lot of credibility out there.

They are the ones who often, in these kinds of programs, end up taking the hit and get those lower margins, rather than some of the manufacturers. And I would hope that through the PBM mechanism that you have described that we would see a fair distribution of that lower margin as well as higher volume which, I agree with you, can end up being a win-win if it is properly administered. And I know you will be flexible as this program is put in place as well to be sure that we are getting good information as to how it is working, to insure that seniors are benefiting, but also our mom-and-pop stores and pharmacies can continue to provide that good service that they do.

I wondered if you could comment on another issue that has arisen in connection with the card, again, which I support. But that is with regard to nursing homes. As you know, many of our seniors who are in nursing home facilities get very specialized care in the area of prescription drug coverage. This is an area that involves a lot of intermediary companies that provide this care, and it is unclear to me how the prescription drug card would relate to those seniors who are in the nursing home context. I wonder if you could comment on that or perhaps respond in writing.

Secretary THOMPSON. Well, first off, the pharmacist within the nursing home is going to have to enroll. They are going to have to meet certain requirements in order to enroll with the PBM. The PBM will have certain things that they offer. They are going to have to be willing to sell the drugs at the price that was negotiated with the pharmaceutical companies and pass that on to the senior resident in the nursing home. And the senior is going to have additional choices. They will be able to have their choice either to go in-house or go to another pharmacy in the community, or apply for the drugs through a mail order.

So the senior is going to have many choices. And it should be one in which it is going to be beneficial to everybody involved.

Mr. PORTMAN. Are you concerned about the disruption of what often happens now, which is more of a managed care approach to seniors, the unit doses that they use, the drug packaging that is done and is very specialized, as you know, and the 24-hour emergency delivery services they provide at nursing homes, other specialty services? Do you think that this will disrupt that kind of managed care approach to drug benefits currently?

Secretary THOMPSON. I don't think so, Congressman, but, you know, this is really in the embryonic stages. But I don't believe that. And I just would like to thank you for your leadership on a lot of reform issues. And hopefully this is one that we can listen to you for some advice and suggestions on how we can improve it.

Mr. PORTMAN. Absolutely. One other quick question. You talked earlier about how this may differ from some existing programs. One that has come to my attention, the Readers Digest card, apparently that is a program that is popular among some seniors in my area. How will this differ from the Readers Digest approach?

Secretary THOMPSON. Well this is going to be much, much broader. I mean, this is going to be—

Mr. PORTMAN. Bigger discounts because of higher volume?

Secretary THOMPSON. Bigger discounts. It is going to be broader. It is going to have all seniors, you know, that want to really get involved with Medicare, you know, to be able to have the seal of good housekeeping approval by CMS. And I would just think that the weight of that seal and the support of the Federal Government supervising the private sector—the beauty of it is the private sector is going to do it. The Federal government is not going—it is not going to cost us anything except for the time put in to reviewing, whether or not the PBMs are doing a good job. And with that kind of partnership, I just think it is going to be a tremendous opportunity for seniors to get the best discounts possible.

Mr. PORTMAN. Thank you very much.

Mr. RAMSTAD. The gentleman's time has expired. The gentleman from Wisconsin, Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Ramstad. Mr. Secretary, I think this whole drug card business is being overstated, not only in the press, but also in your comments today. I think the direct answer to Mr. Collins' question as to how this is going to affect the local pharmacies. One of two things are going to happen. Number one, because of these cards being used by Medicare recipients, they are going to be forced to give them the discount and it is going to come off of their bottom line. It is going to come off the small spread they have from filling prescriptions.

Or the other thing which I think is going to happen, and this is probably more realistic, is the bulk of these PBMs are going to go to mail order, and so our local pharmacist, the pharmacist in Elroy, Wisconsin, is going to get X out of the deal, Okay? But this whole benefit, or this whole discount drug card is liberalism at its worst. At least the traditional liberals, when they come up with a program like this to benefit people, they provide some Federal financing or government financing for it, Okay?

But what we are doing now, this administration is promoting this program, and it is going to come out of other people's hides. All right? These benefit managers, the PBMs, for the most part, we have seen they don't necessarily pass off or pass on the savings that they get through the volume purchasing. But I am aware that four companies that are dealing with the White House on this drug discount card now, 90 percent of the business they do is all mail order.

So if we are worried about our local pharmacies, this business is going to be gone because if you want to save 10 or 12 percent you

are going to have to mail your scrips down to Florida and 5, 6 days later, you are going to get the medications back.

Mr. Secretary, you indicated that in modernizing medicine or Medicare, you are really hoping to have some type of a bipartisan solution. My question is, has your agency, has HHS currently been working with congressional staff on trying to develop this proposal to modernize Medicare?

Secretary THOMPSON. Yes.

Mr. KLECZKA. Okay. Has any Democratic Members of Congress or staff been invited to participate?

Secretary THOMPSON. Yes, many.

Mr. KLECZKA. Okay. No one that I am aware of on the Committee, Democrats I should say, or their staff had been invited. Am I missing something?

Secretary THOMPSON. Congressman Kleczka, I would love to work with you.

Mr. KLECZKA. Well, I am just saying, have you invited Pete Starks' staff, who is the ranking minority Member on the Subcommittee?

Secretary THOMPSON. I believe—I don't know if—how many—

Mr. KLECZKA. See, we keep talking bipartisanship. But now in the development of the reform, I am not aware of any Democrat Members of Congress or a staff person invited.

Secretary THOMPSON. Well, Congressman, that is just not true because we have worked considerably on a bipartisan basis.

Mr. KLECZKA. Well could you identify a staff person that has been part of this discussion?

Secretary THOMPSON. I can't identify a staff person right now, but I can tell you that I have met with many Congressmen, Democrats and Republicans.

Mr. KLECZKA. No, I am talking about actual discussions on putting together this modernized Medicare bill.

Secretary THOMPSON. I was not in the meetings, but I have instructed them that they meet with both political parties as often as they possibly can, and—

Mr. KLECZKA. Could you check with the staff and maybe—I keep wanting to call you Governor.

Secretary THOMPSON. But I would like to also point out about the card. You are under a misinterpretation on one thing, Congressman Kleczka, that these PBMs cannot only do mail orders. That is prohibited. They also have to enroll the pharmacists, so it is not only going to be mail order. It has got to be both.

Mr. KLECZKA. And Mr. Pharmacist, even though you have a very small margin in writing these or filling these prescriptions, we are going to send you a hundred seniors with these cards, you are going to have to eat the cost, right?

Secretary THOMPSON. No.

Mr. KLECZKA. There is no way they are going to get the drugs cheaper from the pharmaceutical company. That is why the Drugstore Association now is livid over this thing. It is a great liberal proposal, but we are not putting any money where our mouth is.

Secretary THOMPSON. Congressman, we are hopeful and we believe strongly that the large discounts are going to come from the pharmaceutical companies, not the pharmacists. That is where the

big savings are going to be. And yes—we, you are absolutely correct. We do not put any Federal dollars into this thing. We think the beauty of the program is that it is going to be run by the private sector, and we think the pharmacists, the local pharmacists in your congressional district and I know many of them, are going to benefit from this because they are going to get increased individual traffic from the people that will be able to purchase drugs now.

Mr. KLECZKA. That is a concern they are sharing with me. They, Governor, don't agree with you.

Secretary THOMPSON. I know a lot of people don't, but—I don't think you can say that, and I know I can't at this point in time. I just think that the program is going to work and I think that we will have to come back and discuss it in 6 months, and we will see if you are correct or I am correct.

Mr. KLECZKA. Okay. Thank you very much.

Mr. RAMSTAD. The gentleman's time has expired. The gentleman from Pennsylvania, Mr. English.

Mr. ENGLISH. Thank you, Mr. Secretary. Mr. Secretary, I have learned a great deal from your testimony today and I have seen you go through a battery of questions and even be accused of liberalism, which is something I don't gather you were accused of all that often when you were up at Wisconsin, but Mr. Kleczka may have a different take on that.

Mr. KLECZKA. Will the gentleman yield?

Mr. ENGLISH. No, I would prefer to ask my question. Mr. Secretary, we in northwestern Pennsylvania are very pleased that you have made it such a high priority to move forward on a Medicare prescription drug program to the extent that you are able to now create a discount drug card and looking toward—and we recognize that your card is just a step toward a comprehensive drug program under Medicare.

One of the issues raised by my colleague from Pennsylvania, Mr. Coyne, had to do with States like Pennsylvania that already have made the investment in their seniors and created their own State drug program. One of the things we learned in last year's debate is that in order to accommodate seniors in States like that, it is important to have a drug program that is flexible enough that you can wrap it around existing benefits.

Do you view it as a priority to create a program at the Federal level that can be integrated with State programs, and what issues do you see with that integration?

Secretary THOMPSON. Well, I think you have to have a program that is going to be—I don't know if "integration" is the proper word. But you have to be able to have a program that is going to work in concert with the State program, Congressman English. You have got the Medicaid program. And that, of course, is going to pick up in a lot of cases where Medicare leaves off. So what we have to do, I don't know if integration—but we have to be able to be willing to look at the Medicaid program as well. I don't think we can do it all this year, but if we could build the Medicare Program in a strong fashion and give people a choice, I think it is going to benefit the State programs, especially your PACE Program in Pennsylvania and your Medicaid program and will strengthen it if Medicare is able to do a lot of things.

For example, if we are able to develop a better prevention program and be able to get people before they get really sick, that is going to benefit the State dollars. And so all of this together, this building one upon the other, is going to be helpful for Pennsylvania as it is for the State of Wisconsin.

Mr. ENGLISH. One of my other colleagues had expressed a concern that actions in Congress or the administration might "obviate the availability of resources for Medicare," which in northwestern Pennsylvania, we would rephrase that as not enough money. I am wondering, looking at the budget that the President's leadership pushed forward, having made a commitment to, as I recall over \$300 billion to modernize Medicare, and put in place a prescription drug program, which is double the investment that the House had contemplated last year in passing our bipartisan bill, do you feel, at this point, that the House has committed the resources in its budget to modernize Medicare?

Secretary THOMPSON. I think you have done an excellent job, Congressman, and I think it shows how serious this Congress is about addressing this problem. And let us hope that we are going to be able on a bipartisan basis to do the job that is necessary for our seniors across America. And that includes prescription drugs. That means a Medicare Program with expanded benefits for catastrophic coverage and for prevention, and also put it on a financially secure basis so that your children and grandchildren are going to be able to have the coverage that they deserve.

Mr. ENGLISH. And on that point, you have been very correctly raising the issue of reform as part of the picture. My understanding is that absent reform, combined Medicare spending will quadruple from 2.2 percent of GDP to 8.5 percent by the year 2075. You are an actuary of this, or I am sorry, a trustee?

Secretary THOMPSON. Yes, sir.

Mr. ENGLISH. Is that accurate? And do you feel that we have to fix this all at once?

Secretary THOMPSON. That sort of actuarial study has certainly shown, but it is even more imminent than 2075 because 2016, you are going to see a precipitative drop as far as out go versus income. And so really, in 2016 there will be some built up IOUs from the government that will keep it solvent until 2029. But 2016 you start going the other way. And so it is important, you know, for people to understand. It is not 2029. It is not 2075. It is 2016 that really is the date that is the most prevalent one to consider.

Mr. ENGLISH. Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman's time has expired. The Secretary has been here for 3 hours, and he has to leave no later than 1:10. So if possible, so that all three of you can get your questions in, I will now call on the gentleman from Massachusetts.

Mr. Neal, if you could possibly shorten your time so the other two colleagues could also inquire.

Mr. NEAL. Thank you, Mr. Ramstad. Well, I just want to compliment the Secretary on the appointment of Mr. Scully. I think that is an exceptional appointment and I won't be going to your deposition, I can tell you that.

Secretary THOMPSON. Thank you, Congressman.

Mr. NEAL. Mr. Secretary, yesterday I met with Steve Crosby, who is the Secretary of Administration and Finance in the State of Massachusetts and they oversee Medicaid and Medicare issues for the State. He talked to me about many of the consumer issues that are pending in Massachusetts right now, including efforts to coordinate drug purchasing for those enrolled in the senior pharmacy assistance program, Medicare and Medicaid, State workers and the underinsured and the uninsured.

My question is, how will the administration's discount drug plan interact with the State-run plan like the one that is being developed in Massachusetts at the moment? And could my constituents participate in both this new Federal program and a State discount program as well? And will this new Federal benefit preempt State initiatives like those being developed in Massachusetts? If the Federal discount is better for one drug and the State discount is better for another, can my constituents participate in both plans and shop for the best priced drugs, and if so—

Secretary THOMPSON. If they are seniors, yes.

Mr. NEAL. Yes to all three?

Secretary THOMPSON. Pardon?

Mr. NEAL. Yes to all three parts of the question?

Secretary THOMPSON. If they are a senior, they will be able to participate in the State program and the Federal program if they so desire. And this program is not going to interfere with any State programs like Massachusetts or any other State that is developed. But what it intends to do, really, is to help the uninsured, the 27 percent of the seniors in America, which is approximately 12 million, 10 to 12 million Americans that don't have any drug coverage whatsoever. And they are the individuals that pay the highest price because they have nobody running interference for them, either with the drug companies or the pharmacist, to get the best price. And another beauty of this card is a year from now we are going to have all of the listings, the PBMs have got a list, all of the drugs they are selling, both the generic drugs as well as the main drugs.

Mr. NEAL. One last question, and then I will use a point of reference. The hospitals where I live are still complaining that they are in trouble. Levels of reimbursement they say are not adequate. And I know part of it rests with the Balanced Budget Act. But the other part of it obviously rests with interpretations that you are going to make in an administrative capacity. But that is across the State. And those are the best hospitals arguably in the world in Massachusetts, and they really are all singing from the same hymnal. They need help.

Secretary THOMPSON. I am hearing that refrain not only in Massachusetts. I heard it when I was in Texas. I heard it and I have heard it in Wisconsin.

Congressman Neal, as you know, the Balanced Budget Act made some changes and there have been some improvements since the Balanced Budget Act. We are looking at ways, and I would appreciate your suggestions on how we might be able to restructure and improve the payment structures. But we also, under, you know—

Mr. NEAL. Be assured I am going to be on Tom Scully big time about this issue.

Secretary THOMPSON. Pardon?

Mr. NEAL. Be assured I am going to be on Tom Scully big time about this issue.

Secretary THOMPSON. He is here right now smiling, I am sure, behind me and knows that full well.

Mr. NEAL. Thank you, Mr. Secretary.

Secretary THOMPSON. Thank you, Congressman Neal.

Mr. RAMSTAD. I thank the gentleman from Massachusetts and I join in his comments of praise about Mr. Scully. And I now yield to the gentlelady from Florida, Mrs. Thurman.

Mrs. THURMAN. Thank you. And since Mr. Scully is here I just want to also tell you, Mr. Thompson, he is very good at getting us back on the phone after we have made a phone call. So that just adds to whatever everybody else has said. But I need to go into a couple of questions.

You announced a couple of months ago about changing the date on the HMO Medicare choice program information going out to seniors. I have to tell you that has created a huge issue in the district. I mean, absolutely these people are scared. They don't understand. They don't know why, and they are calling it a disaster. It doesn't make sense. How are we going to get the word out?

But with that in mind, I also have been able to pull your budget for the next year, particularly on the area of Medicare education program. I wish some of our appropriators were here, because it actually has been reduced by about \$48.2 million over this next year, so when you do that, I don't know how we are going to be able to do this educational program and get this information out in a timely fashion for some of these folks. And I just bring that up because they are very, very scared.

Secretary THOMPSON. Congresswoman, I understand that. But what we are trying to do, and we were faced with a real—

Mrs. THURMAN. I know.

Secretary THOMPSON. We were faced with a real dilemma and the real dilemma was that a lot of the Medicare-Plus Choice HMOs were saying, you know, we don't —we are going to have to pull out. And if we could give a little bit more time in order to look at our financing and—we are trying to keep them in. And I understand, you know, your constituents and we are trying to be very sympathetic to that, and we are trying to figure out a way—

Mrs. THURMAN. But I am actually trying to help you here, because I want the rest of the Congress to understand that we are cutting your budget to do exactly what you are trying to get done, and that is to make sure they have the right information. And these are people who, in fact, have been pulled out last year and only by a fact of getting an incentive payment in there were we able to bring back into, so they are back in there.

Secretary THOMPSON. Thank you for your help.

Mrs. THURMAN. The other thing I am just going to bring up, you don't have to answer it right now, is nurses shortage, a huge issue across this country, part of the hospital costs that are going up. They can't find nurses. We are not doing anything about education. I would like to call on your Governors to, in fact, start implementing some programs whether it is some kind of scholarship aid, whatever, to help in that area.

Secretary THOMPSON. I agree with you. I couldn't agree with you more.

Mrs. THURMAN. The other thing that I would like to talk to you about, and this is a concern to me. And it is actually an amendment that I have run a couple of times in this Committee. The card is great, but the fact of the matter is I tend to agree, at looking at some of these issues, I don't think the pharmaceutical companies are going to give us a break. I just don't believe it. I mean, they are out there already on this patent trying to extend patents so that they can have additional time instead of putting in a generic.

So I don't know how we are going to get them to work. But there is a way the Federal government could have done this, and that was through the Federal supply program, and in fact, that if I just look at like Drugstore.com or Merck Medco, if you take the 10 percent and the 25 percent that you gave, I will tell you, and I will show you those numbers. But, in fact, the Federal supply schedule is still lower than even what this card can do and quite frankly it doesn't cost the Federal government any money. We are just negotiating in an area that we have already negotiated. So I just lay that on the table; something to think about.

Secretary THOMPSON. Thank you.

Mrs. THURMAN. I think it is something that could be done. We do VA contracts already. It is something that we could—actually cost nothing to the Federal Government and would work.

The last thing that I am going to say, though, is somebody mentioned in this Committee just a little while ago about Blue Cross, Blue Shield and all of these, you know, opportunities that we might have in providing senior citizens plans. They are already leaving. I mean they are not—I don't know how we are going to encourage them back. We know for a fact that of the 15 percent in managed care today we are going to be down to 12 percent by the end of this year. I mean, that has been kind of out there from what I—

Secretary THOMPSON. I am afraid you are correct. I hope that we can stem the bleeding, but I am afraid you are correct.

Mrs. THURMAN. So, but even when we add these choices, I mean, right now already, one of the reasons those folks are telling us they are leaving is because we don't give them enough money. I mean that is their argument. I am not sure that that is the total argument, because I think networking has a lot to do with this and providers participating in it.

So the other issue, especially after all these tax cuts and we continue to get these tax bills, and you know, part of our administration last year said we need to provide some more dollars into Medicare and we needed to save some of that surplus money to do that to strengthen, and in fact, do exactly some of the kind of things you have said.

I am very concerned that we are going to do a lot of these things and the cost is going to be shifted to the beneficiaries, which is what has happened under Medicare Choice programs today. But we will talk. Thank you.

Mr. RAMSTAD. The gentlelady's time has expired.

Secretary THOMPSON. But Congresswoman, I need your help. I need your ideas. I need—

Mrs. THURMAN. Call me, because I haven't gotten that phone call yet.

Secretary THOMPSON. OK.

Mr. RAMSTAD. Mr. Secretary, I know your drop dead time for leaving—

Secretary THOMPSON. You can call me, too.

Mrs. THURMAN. I have.

Mr. RAMSTAD. I will set up a conference call for you. I know the Secretary's drop dead time for leaving is 1:10, but your staff just graciously consented to one more line of questioning.

Mr. DOGGETT. I have about 5 minutes.

Mr. RAMSTAD. So the Chair will recognize the gentleman from Texas for the final questioning, Mr. Doggett.

Mr. DOGGETT. Mr. Secretary, this week we were reminded once again by Phillip Morris that it provides a public service to programs like Medicare because its product kills people before they consume significant amounts of moneys from programs like Medicare. Earlier this month, I requested that you determine whether your Department is fully implementing executive order 13193, concerning our leadership in global tobacco control and prevention programs. And I would just want to draw that to your attention and not ask you for a full response today.

Secretary THOMPSON. Did you write me that?

Mr. DOGGETT. Yes, sir. I did. And your Department has acknowledged receiving the letter and, in fact, I advised them that I would be asking you about it today. But I—it is obvious you don't have that information. And I am just asking you to give it your attention for a prompt written response.

Secretary THOMPSON. OK.

[The following was subsequently received:]

The written response referred to by Representative Doggett regarding the allocation of funds received by the States under the Family Violence Prevention and Services Act is being prepared and will be transmitted to each Member of Congress who signed the incoming letter.

Mr. DOGGETT. Second matter is also one that I am only asking for your prompt written response on. And it concerns a matter that you will be receiving a bipartisan letter on. Earlier this year your Department provided the States a notice of the allocation that they would receive under the Family Violence Prevention Services Act, a subject I know you are personally interested in. Unfortunately, that notice of the allocation was in error. It was inaccurate. And by the time that the Department corrected this allocation, the Texas legislature, in its biannual session, had adjourned. The legislature appropriated, based on the inaccurate information and we feel now that in Texas, and this is not just Texas, but particularly in our State, that there will be hundreds of families that will not have the services through these violence prevention programs because they—

Secretary THOMPSON. Do you know how much money was involved?

Mr. DOGGETT. Yes, sir. I think what we are asking for is a reprogramming of about \$615,000. And so I would just ask you again

if you would take a look at that. You will be receiving that letter shortly, and try to get back with us because it is very important.

On to the key matters that you have testified to in my remaining seconds. In principle number three, when you use the term “approaching retirement” in that guarantee, what do you believe approaching retirement is, agewise?

Secretary THOMPSON. We haven’t made a decision.

Mr. DOGGETT. I mean, does it include, 50, 55? Can you give me a range of what you are talking about?

Secretary THOMPSON. I presume all of those.

Mr. DOGGETT. That it would include people 50 and above but not necessarily below 50?

Secretary THOMPSON. We never made a determination. I would think 50 probably.

Mr. DOGGETT. You—I saw you explain this program the night it was announced on the Lehrer News Hour, and you responded to questions about the Federal Government’s role by saying we don’t pay any money at all. It is beautiful. And I guess some would view it as beautiful and some would view it as a free lunch approach. But my question to you is, if it is beautiful, and it is free to the Federal government, why are you directing it only toward seniors and not to the millions of people in our country that are in exactly the same situation, who pay the highest prices in the world because they happen to be uninsured?

Secretary THOMPSON. You raise a valid point. We just want to make sure that it is successful. We think it is going to be. I know Congressman Kleczka does not believe that it is going to be as successful as I do and we will have to come back here 6 months from now.

Mr. DOGGETT. So you are willing to consider that alternative.

Secretary THOMPSON. Congressman Doggett, I love new ideas. And you have got new ideas, whether it is a Democrat or Republican, I will try and implement it. And I want to work with you.

Mr. DOGGETT. I am glad to hear that. And I am going to come back to that point. But I want to, in these seconds, to be sure that I understand your request for proposal on this, ask that under the discount program that they guarantee that the retail price or the discount price, whichever is lower, will be available with this discount card. Doesn’t that, in itself, suggest that often the retail price is going to be lower than the discount price?

Secretary THOMPSON. It presupposes that in some—

Mr. DOGGETT. That could happen.

Secretary THOMPSON. It could happen, yes. But I would say not often.

Mr. DOGGETT. You say that you are seeking 10 to 25 percent off of retail prices. You don’t mandate any pharmaceutical company in this country to discount its prices, do you?

Secretary THOMPSON. No.

Mr. DOGGETT. And indeed, when you talk about—

Secretary THOMPSON. Listen, I don’t have that power. If you want to give me that power, Congressman, I will do it. All I can do is—Congressman Kleczka says no, he won’t do that. But if you want to give me that power, I will exercise it.

Mr. DOGGETT. Under this program that you have, are you going to provide that any of the discount card providers who can't assure a minimum of 10 to 25 percent will be removed from the program?

Secretary THOMPSON. We will supervise it on an annual basis.

Mr. DOGGETT. Are you going to set that as the minimum?

Secretary THOMPSON. No.

Mr. DOGGETT. I mean, you could have a program with 1 percent, and since I see the red light coming on, let me just go back because I think it is an appropriate place to end, and an important point.

I have done a survey in the course of this hearing. Not one Democrat on this Committee, not one Member of the Committee that has responsibility for Medicare, has been asked to meet with you or Mr. Scully. And I think it is great you are over here. I appreciate the attitude that you have expressed. But the Committee that has jurisdiction, as far as the Democratic side, if you really want us engaged, if this is to be a bipartisan program, it has to be more than happy talk.

Thank you, Mr. Chairman.

Secretary THOMPSON. Mr. Doggett, it is not happy talk. I am on Capitol Hill at least 1 day a week and I will come and see you and talk to you.

Mr. DOGGETT. You have not seen—you have talked about all these meetings with Democrats, with more Democrats than Republicans. But you have not, prior to today on any aspect of this, talked with a single Democrat on this Committee, and I think that is unfortunate and it is similar to some other things that have happened with this administration, where there is good talk about bipartisanship, but it only means photo opportunities, not involvement in decisionmaking.

Secretary THOMPSON. If that is the case, and my staff has not talked to any of your staff, it is unfortunate. We will try and rectify that.

Mr. DOGGETT. Thank you very much.

Mr. RAMSTAD. The gentleman's time has expired. We want to thank you, Mr. Secretary, for appearing before the Committee for 3 hours and 19 minutes, for bringing your bipartisan leadership to Medicare reform. And also want to thank Mr. Scully for being here today and the staff for both of you. Thank you for your hard work and for the attitude that you bring, the spirit of bipartisanship to this important reform. Look forward to working with you. The hearing is adjourned.

[Whereupon, at 1:20 p.m., the hearing was adjourned.]

[Submissions for the follow:]

**Statement of the Advanced Medical Technology Association, AdvaMed**

AdvaMed represents over 800 of the world's leading medical technology innovators and manufacturers of medical devices, diagnostic products and medical information systems. Our members are devoted to helping patients lead longer, healthier and more productive lives through the development of new lifesaving and life-enhancing technologies. AdvaMed is pleased to present this testimony on behalf of our member companies and the patients they serve.

AdvaMed applauds President Bush's Principles for Medicare Reform, released on July 12, 2001, which emphasize the importance of encouraging high-quality health care for all seniors, better coverage of preventive care and treatments for serious illnesses, increased patient access to the most modern health care options and im-

proved management of the program. Medical technologies are key in helping to realize these goals.

**Medicare should encourage high-quality health care for all seniors, including better coverage for preventive care and serious illnesses.**

The rapid pace of innovation for diagnosing, treating and curing diseases and illnesses continues to drive the high quality of health care available to Americans. However, according to the President, “Medicare takes way too long to authorize new treatments. We must act now to ensure that the next generation of medical technology is readily available to America’s seniors.”

The President’s statement underscores the importance of reducing the current delays of 15 months to five years in Medicare patients’ access to new technologies. By keeping pace with advances in medical technology, Medicare can improve patients’ quality of care and put Medicare on solid financial ground.

The Administration can make substantial progress in reducing Medicare delays by:

- **Properly implementing key technology access reforms** in the Benefits Improvement and Protection Act of 2000, including provisions calling for temporary, transitional payments for new technologies in both the inpatient and outpatient settings.
- **Creating a Medicare Office of Technology and Innovation** to improve the Centers for Medicare and Medicaid Services’ (CMS) accountability, openness and coordination in making timely decisions.
- **Establishing decision deadlines to improve accountability.** For technologies subject to a national coverage decision, CMS should take a total of 6–12 months to set coverage, coding and payment policy and make the technology available to patients.
- **Maintaining and strengthening the local Medicare coverage process** as an important channel for early patient access to new technologies. CMS should support local decision making processes to ensure the continuation of timely, flexible access to new technology. A wide range of local contractors should continue to work with public stakeholders in creating new medical policies and assign local codes as needed.

**Medicare should provide better health insurance options, and the management of the government Medicare plan should be strengthened so that it can provide better care for seniors.**

AdvaMed strongly supports reduced bureaucracy and streamlining, but we are concerned that contractor consolidation could impair local coverage decision-making for critical new therapies. AdvaMed emphasizes the continued importance of local decision making to help ensure the prompt and appropriate use of new technologies.

AdvaMed also supports broader reforms to the Medicare program to give consumers the ability to choose among a range of competing health plans, as well as the traditional Medicare program. We believe it will be critical to ensure a minimum number of competing health plans in each geographic area, so consumers who are empowered to choose among competing health plans will make sure they have access to the high-quality, innovative medical technologies and procedures they need.

However, implementation of the President’s plan should not expand Medicare purchasing authority prematurely. AdvaMed firmly believes in the benefits of market-based competition for providing patients with choices for the most current, high quality health care but the way this important change is implemented will have profound effects on its success. It will be crucial not to implement expanded purchasing authority for the Medicare fee-for-service program before a sufficient number of competing private plans are available in all major geographic areas.

**Conclusion**

AdvaMed believes that these reforms, and other important changes related to prescription drugs, will help provide Medicare beneficiaries with the modern, state-of-the-art care that they deserve, within a framework of market-based, competitive health plans. At the same time, the President’s plan would address the solvency of the Medicare trust fund—an essential part of any reform proposal.

The President’s proposal provides great opportunities for seniors to benefit from the unprecedented advances in innovation happening in health care today. We look forward to working with this Committee, the Congress and the Administration on ways to improve the quality of care available to seniors through Medicare and foster the delivery of innovative therapies for patients.

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## Statement of the Alliance to Improve Medicare

### Introduction

The Alliance to Improve Medicare (AIM) is the only organization focused solely on fundamental, non-partisan modernization of the Medicare program to ensure more coverage choices, better benefits (including prescription drug benefits), and access to the latest in innovative medical practices, treatments and technologies through the Medicare system. AIM coalition members include organizations representing seniors, hospitals, small and large employers, insurance plans and providers, doctors, medical researchers and innovators, and others.

The structure of the traditional Medicare program has changed little in more than three decades and, consequently, has not kept pace with many of the dramatic improvements in health care delivery. AIM is dedicated to achieving comprehensive modernization of the traditional Medicare program through policy research and educational programs for Members of Congress and their staff, the media, and the American public.

AIM applauds the Bush administration's recognition of the need to strengthen and improve the Medicare program to provide high quality health care for senior citizens. AIM shares many of the Bush Administration's principles for Medicare modernization including support for providing more and better coverage options, improving coverage of preventive care services, strengthening the program's financial foundation, and reducing regulatory burdens on beneficiaries, health plans, and providers.

AIM also supports access to prescription drug coverage provided as part of broader modernization. AIM members support an integrated, market-based Medicare drug benefit. The discount card program proposed by the Bush Administration is a way to assist seniors who need prescription drugs in the short-term. AIM urges Congress and the Administration to continue work toward a long-term, integrated drug benefit for all seniors.

### Key Principles for Medicare Modernization

AIM has identified seven key principles to guide Medicare modernization efforts. These principles seek to improve both the administration of the Medicare program and the benefits provided to program beneficiaries.

First, AIM supports improvement of health care coverage through better coordination of care including health promotion and disease prevention efforts. The traditional Medicare program has not kept pace with private sector benefits and plans offering preventive health care and screening measures such as annual physicals, hearing and vision tests, and dental care. Medicare beneficiaries, more so than other population age groups, can benefit from these preventive measures which can help reduce long-term costs and ensure appropriate, early treatment of health problems. Private sector Medicare providers should have the flexibility to incorporate these measures as part of basic health care services.

Second, AIM supports improvement of health care coverage through increased consumer choice. Medicare beneficiaries should have the option to choose from a range of coverage options similar to those available to Members of Congress, federal employees and retirees, and millions of working Americans under 65 years of age who are covered by private plans. The Medicare managed care program, Medicare+Choice, seeks to provide these types of coverage options to seniors nationwide. Unfortunately, inadequate payments and excessive regulation of private sector providers participating in Medicare+Choice have seriously constrained the ability to expand coverage areas and have caused numerous plans to withdraw from coverage areas where reimbursement was inadequate to cover even the costs of basic care.

Third, AIM supports improving coverage through increased competition among all plans and providers in the Medicare program. Medicare's managed care option, the Medicare+Choice program, is an alternative to and competitor with traditional fee-for-service Medicare. The federal government, through the Centers for Medicare and Medicaid Services (CMS), currently regulates Medicare+Choice plans while also acting as a participant itself through the traditional fee-for-service program. AIM believes this dual role is anti-competitive. Medicare reform and modernization efforts must be evaluated based on success in increasing market competition and availability of basic, affordable coverage to Medicare beneficiaries, not on increasing CMS's regulatory powers and oversight activities.

Fourth, AIM believes prescription drug coverage should be provided to all Medicare beneficiaries as part of comprehensive, market based Medicare modernization.

The opportunity for reform and modernization is presented by the recognized need to cover prescription drug benefits for Medicare recipients. Congress and the Administration should take this opportunity and not simply layer a new, stand-alone drug program onto the traditional Medicare program without addressing the program's outdated and inadequate financial and structural systems. The program in its current form cannot meet the coming challenges presented by the retirement of the baby boom generation which will more than double the number of Medicare beneficiaries. Any Medicare reform proposal must address the real structural and financial problems of the Medicare program.

Fifth, AIM urges Congress to continue to review and address the financial crisis facing health plans and providers. Adequate financing is necessary to establish a solid foundation upon which to build a better Medicare and ensure the long-term financial integrity and solvency of the Medicare program. Health plans, hospitals and doctors have been hit hard and patient care has been and will continue to be affected. Congress recognized the damage caused by BBA '97 and has provided some restorations in payment funding. These small repayments represent a good start at addressing the financial crisis caused by the cuts. AIM encourages Members to continue to ensure appropriate and timely payments for these providers and plans to ensure appropriate care for Medicare beneficiaries.

Sixth, AIM believes that the current rigid and outdated Medicare benefit structure and bureaucracy must be replaced. A recent AIM report outlined Medicare regulatory burdens on both Medicare beneficiaries and on health plans and providers. The report, "Improving Medicare Management for Everyone", identifies areas of complexity for both senior citizens and providers including health plans, hospitals, and medical technology innovators. AIM identifies beneficiary concerns including the lack of clear information on benefits and eligibility, access to prescription drug benefits, and difficulties understanding Medicare paperwork. The report also outlines provider regulatory burdens including inconsistent Medicare program policies, slow responses to provider concerns and inquiries, and an inflexible Medicare bureaucracy.

Finally, AIM believes Medicare administrators must reduce excessive program complexity and bureaucracy caused by the more than 110,000 pages of federal rules, regulations, guidelines and mandates. AIM supports the elimination of real fraud and abuse in Medicare but our members believe this can be achieved without relying on unnecessarily complex and heavy-handed regulation. Providers and plans must not be forced to divert resources from patient care in order to respond to ever-changing regulations.

### **Conclusion**

AIM urges the 107th Congress to consider sensible, long-term solutions to the problems confronted by the Medicare program and by Medicare beneficiaries and we urge Members to work together on a bipartisan basis to achieve comprehensive Medicare reform. AIM appreciates the opportunity to submit this statement for the hearing record and we look forward to working with the Committee as they examine options for Medicare.

## AIM Principles for Medicare Modernization

July 2001

AIM Principles for Medicare Modernization	Address Financial Crisis and Ensure Financial Future	Improve Coverage through Expanded Benefits	Improve Coverage by Increasing Consumer Choice	Improve Coverage through More M+C Competition	Offer Drug Benefit through Medicare Modernization	Cover Medical Technologies More Quickly	Reduce Medicare Bureaucracy and Complexity
<p><b>S. 357</b></p> <p><b>(Senator John Breaux (D-LA) and Senator Bill Frist (R-TN))</b></p> <p><b>(Based on National Bi-Partisan Commission on the Future of Medicare)</b></p>	<p>YES.</p> <p>Redefines solvency for Part A and Part B Trust Funds. (Sec. 101; new SSA Title XXII, Part D)</p>	<p>NO.</p> <p>No provisions to improve fee-for-service Medicare program benefits by adding preventive benefits.</p>	<p>YES.</p> <p>Restructures as “competitive premium system” to encourage plans to stay in program and/or expand operating areas. Creates new agency to oversee managed care program. (Title III)</p>	<p>YES.</p> <p>Reforms fee-for-service and Medicare managed care programs by creating separate management offices and Medicare Board. (Sec. 101; new SSA Title XXII, Part E)</p>	<p>YES.</p> <p>Offers drug benefit as part of “High Option” benefits package through fee-for-service and Medicare managed care plans. Includes reforms for both programs. (Sec. 101; new SSA Title XXII, Part A)</p>	<p>NO.</p> <p>No provisions to speed approval of new medical technologies in fee-for-service program. Medicare managed care plans are urged to quickly cover new technologies.</p>	<p>NO.</p> <p>No provisions to reduce overall government regulation of Medicare beneficiaries, health plans or providers.</p>
<p><b>S. 358</b></p> <p><b>(Senator John Breaux (D-LA) and Senator Bill Frist (R-TN))</b></p>	<p>YES.</p> <p>Redefines Medicare solvency. Requires annual report on trust fund status. (Title I, Subtitle B).</p>	<p>NO.</p> <p>No provisions to improve fee-for-service Medicare program benefits by adding preventive care.</p>	<p>YES.</p> <p>Improves and strengthens Medicare managed care program through competitive system modeled FEHBP. (Title III)</p>	<p>YES.</p> <p>Establishes separate Medicare agency to run Medicare managed care program and drug benefit. (Title I, Subtitle A)</p>	<p>NO.</p> <p>Drug benefit is not incorporated into standard benefit package.</p>	<p>NO.</p> <p>No provisions to speed approval and coverage of new medical technologies in fee-for-service. Medicare managed care plans are urged to quickly cover new technologies.</p>	<p>NO.</p> <p>No provisions to reduce overall government regulation of Medicare beneficiaries, health plans or providers.</p>

<p><b>S. 1135</b> <b>(Senator Bob Graham (D-FL))</b></p>	<p>Somewhat. Proposal would index Part B deductible to inflation and change Part B monthly premium to sliding scale payment based on income. (Title V)</p>	<p>YES. Fee-for-service and Medicare managed care programs would include preventive benefits. (Title IV)</p>	<p>NO. No provisions to improve and increase consumer choices for coverage.</p>	<p>Somewhat. Allows competition for select fee-for-service contracts. (Title I, Sub. D) Allows competition for drug benefit contracts. (Title III, Sec. 301) No provisions to improve competition in Medicare managed care.</p>	<p>NO. Drug benefit is not incorporated into standard benefit package.</p>	<p>YES. Proposal seeks to improve and speed coverage decisions for new technologies. Proposal does not address coding or payment. (Title I, Sec. 101)</p>	<p>NO. No provisions to reduce overall government regulation of Medicare beneficiaries, health plans or providers.</p>
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**Statement of the National Association of Chain Drug Stores, Alexandria,  
Virginia**

Mr. Chairman and Members of the Committee. The National Association of Chain Drug Stores (NACDS) appreciates the opportunity to submit this statement for the record regarding our perspectives on the Bush Administration's principles for Medicare reform. NACDS membership consists of over 180 retail chain community pharmacy companies that employ over 100,000 pharmacists. The chain community pharmacy industry is comprised of more than 33,000 retail community pharmacies, including 20,000 traditional chain drug stores, 7,800 supermarket pharmacies and 5,300 mass merchant pharmacies. Chain operated community retail pharmacies fill nearly 63% of the more than 3 billion prescriptions dispensed annually in the U.S.

NACDS has reviewed the President's Medicare Reform Principles and believes that they are broad enough to be realistic, and indeed, even supportable goals for Medicare reform. However, as the community pharmacy industry has learned over this past week, the specific "details" are important regarding how these principles will impact Medicare beneficiaries. Therefore, it is difficult to make any final judgement about how these principles will impact our industry and the beneficiaries that we serve.

For example, the principles talk about better "prescription drug benefit coverage" and better "coverage for preventative care and serious illness for seniors". We do not see how these principles could be realized through a prescription drug discount card program. Indeed, this program seems to defy these principles. We strongly object to this program, which was announced last week by the Administration. In fact, NACDS and the National Community Pharmacists Association (NCPA) are seeking to enjoin the Department of Health and Human Services from moving forward with this program because of the economic harm that it will inflict on community pharmacy, and the false promise that it represents for our nation's Medicare beneficiaries in reducing the cost of medications. We have attached to this statement a copy of the complaint that NACDS and NCPA filed this week. Found on the NACDS web site at <http://www.nacds.org/user-documents/DiscountCardLawsuit.pdf>.

In an effort to promote real reform of the Medicare program and the establishment of a true, comprehensive pharmacy benefit for seniors, we have developed our own principles with seven other national pharmacy organizations (see attached).<sup>1</sup> We intend to use these principles to evaluate our support for the various Medicare pharmacy benefit proposals that have been introduced and may be marked up by this Committee. We appreciate the opportunity to submit this statement for the record and look forward to working with the Administration and the Congress in developing a reformed Medicare program.

**"Pharmacy Benefits All" Coalition**

**A Unified Agenda for American Pharmacy—June 2001**

American College of Clinical Pharmacy (ACCP)

American Pharmaceutical Association (APhA)

American Society of Consultant Pharmacists (ASCP)

American Society of Health-System Pharmacists (ASHP)

Food Marketing Institute (FMI)

National Association of Chain Drug Stores (NACDS)

National Community Pharmacists Association (NCPA)

National Council of State Pharmacy Association Executives (NCSPAEE)

As policymakers discuss a comprehensive outpatient pharmacy benefit for seniors, the "Pharmacy Benefits All" Coalition encourages Congress and the Bush Administration to carefully consider the views of the nation's pharmacists and pharmacies—one of our nation's largest, most accessible, and consistently most trusted group of health professionals.

**Pharmacy Organizations: Who We Represent**

Our organizations represent the spectrum of American pharmacy practice—independent and chain community pharmacists and pharmacies; hospital and health-

<sup>1</sup>Document reflects founding members of the Pharmacy Benefits All (PBA) Coalition. Other organizations continue to join.

system pharmacists; clinical pharmacists in academic health centers, medical group practices, and clinics; pharmacists practicing in managed care organizations; consultant pharmacists in long-term and senior care facilities; home health care pharmacists; and virtually every other type of pharmacist and setting where patient care and medication use occur. We are unified in our core beliefs concerning the development of an outpatient pharmacy benefit for seniors.

#### **Outpatient Pharmacy Benefit For Seniors: What We Believe**

- ***Seniors Should Have Access to a “Pharmacy Benefit”—Not Just a “Drug Benefit”***

We believe that seniors should have access to a comprehensive pharmacy benefit. This includes coverage for the most appropriate medication for the senior, as well as the professional services of pharmacists and pharmacies that assure effective outcomes from medication use.

Pharmacists can work together with the patient and their physicians to help assure that medications are clinically appropriate and cost effective. As a result, preventable drug-related problems, such as side effects and drug interactions, can be avoided. For these reasons, we believe that seniors should have access to a “pharmacy benefit,” not simply a “drug benefit.” In addition to providing the medication, a meaningful pharmacy benefit would include important components such as collaborative medication therapy management (MTM) services for seniors with chronic medical conditions, refill reminders, extended pharmacist counseling, and outcomes monitoring and evaluation.

Some proposals do not meet these important tests. For example, “prescription drug discount card” programs do not provide adequate pharmacy coverage for seniors, and represent price controls on pharmacies, which are private-sector businesses. Moreover, simply providing coverage for medications is only part of the answer to assuring that seniors have access to a comprehensive pharmacy benefit. Medications are safe and effective only when they are used appropriately. Inappropriate medication use leads to hospitalizations, emergency room visits, and other unnecessary medical costs for which Medicare is already paying a substantial price.

Seniors recognize that pharmacists are the most qualified health professional to provide this level of care and service. Seniors should have the choice of and access to the pharmacist and pharmacy that best meet their specific health care needs.

- ***An Outpatient Pharmacy Benefit Should Pay Pharmacists and Pharmacies for the Services that Meet the Special Needs of the Senior Population.***

Any outpatient pharmacy benefit must recognize that the nation’s pharmacists and pharmacies are the individuals and entities that actually provide the medications and professional services that are essential to assure that medications are optimally used.

Payment to pharmacists and pharmacies for providing these products and services must recognize the important health care needs of the senior population, including such services as medication compliance packaging, prescription compounding, and patient education and counseling. Payments should be reasonable and adequate to cover the professional, administrative, and business costs of providing these products and services—as well as a reasonable return on investment—in all pharmacy practice settings in which the care and services are provided.

- ***Pharmacists and Pharmacies Should Deliver Care to Seniors under the Outpatient Pharmacy Benefit.***

Most of the senior outpatient pharmacy proposals introduced to date turn the administration, management, and delivery of services over to “private sector” entities sometimes referred to as prescription benefits managers (PBMs). For example, under several existing proposals, PBM’s are charged with “managing care,” “developing drug formularies,” “increasing generic drug use,” “negotiating discounts with pharmaceutical manufacturers,” “placing price controls on pharmacies,” and “providing medication therapy management programs to seniors.”

PBMs can and do have an important role in performing many of the administrative tasks associated with providing the pharmacy benefit to seniors. We believe that the nature and scope of “patient care and cost management” tasks that these proposals would assign to PBMs needs further thorough discussion. Pharmacists and pharmacies are the real “private sector” providers of care and service to patients. Pharmacists and pharmacies provide services and work with patients at their point of care to help assure appropriate medication use and accurate dispensing. Senior citizens will ultimately rely on pharmacists and pharmacies to achieve the outcomes we all seek for a successful outpatient pharmacy benefit.

**What We Pledge**

Our organizations are jointly committed, prepared, and able to work with the 107th Congress, the Bush Administration, the pharmaceutical industry, HCFA, physician organizations, senior advocacy groups, and other interested parties to help design an outpatient pharmacy benefit for seniors that improves medication use, helps control overall health care costs, and enhances the quality of life.

An outpatient pharmacy benefit for seniors will be the single most substantial and important addition to the program since its inception 35 years ago. We must assure that any new program established provides the most cost effective pharmacy benefit to seniors and the Medicare program. Seniors, taxpayers, and the public at large deserve nothing less than our best effort.

[An additional attachment is being retained in the Committee files.]

