THE PRESIDENT'S FISCAL YEAR 2008 BUDGET FOR THE CENTERS FOR MEDICARE AND MEDICAID SERVICES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

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THE PRESIDENT'S FISCAL YEAR 2008 BUDGET FOR THE CENTERS FOR MEDICARE AND MEDICAID SERVICES

WEDNESDAY, FEBRUARY 13, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:03 p.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (Chairman of the Subcommittee), presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 06, 2007
HL–1

CONTACT: (202) 225–3943

Hearing on the President's Fiscal Year 2008 Budget with Acting CMS Administrator Norwalk

House Ways and Means Health Subcommittee Chairman Pete Stark (D–CA) announced today that the Subcommittee on Health will hold a hearing on the Medicare portions of the President's Fiscal Year 2008 budget proposals. **The hearing will take place at 2:00 p.m. on Wednesday, February 13, 2007, in Room 1100, Longworth House Office Building.**

The Subcommittee will examine the President's Fiscal Year 2008 budget proposals relating to the Centers for Medicare and Medicaid Services (CMS) programs. In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. 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.

FOCUS OF THE HEARING:

On February 5, 2007, President George W. Bush submitted his Fiscal Year 2008 budget to Congress. The spending and policy proposals related to the Centers for Medicare and Medicaid Services in the Department of Health and Human Services fall under the jurisdiction of the Committee.

In announcing the hearing, Chairman Stark said, "The programs administered by the Centers for Medicare and Medicaid Services are vitally important to American families. Congress and the Administration must work together to ensure that these programs are working effectively for beneficiaries, providers, and taxpayers. I welcome the opportunity to discuss these critical issues with Acting CMS Administrator Leslie Norwalk."

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*110th Congress*" from the menu entitled, "*Committee Hearings*" (*http://waysandmeans.house.gov/Hearings.asp?congress=18*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Tuesday, February 27, 2007**. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item 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 submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies 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. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

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 STARK. In an effort to accommodate those who want to get home before they get snowed in and have to spend the night here, I will proceed before all of our colleagues are here. I think they'll be coming in and out from the debate on the floor, and I appreciate Ms. Norwalk's coming over.

I think the Government is closing early this afternoon, so we'll try and move along.

It's our first hearing, I'm happy to have Ms. Norwalk here.

I understand that Ranking Member Camp is on his way, and I'm happy to have him here.

I want to thank you for appearing at our first hearing, and I know it won't come as a surprise to you, Ms. Norwalk, that I'm disappointed by the President's budget, and there's a bit of a difference between the Congress and the Administration's priorities, I think, for health care.

From 1984 to 1995, this Subcommittee and various Republican Administrations would often disagree about how to split reimbursement between rural and urban providers, or what percentage to take off market basket for various providers, but we all worked toward the same goal, and that was preserving and improving Medicare as a guaranteed defined benefit for America's seniors and people with disabilities.

Instead of renewing that spirit, the President's budget cuts some 300 billion out of Medicare and Medicaid over the next decade and leaves some 50 billion in overpayments with private, mostly for-profit plans in place.

Even worse, this budget enhances provisions inserted into law as part of the Part D prescription drug plan, which will hasten Medicare's fiscal problems, or demise, perhaps.

The so-called 45 percent trigger, rather than a recommendation, would allow the President to be empowered to force across the board automatic cuts to limit Government spending, and that is a sure path to turning Medicare into a voucher program.

The President's budget increases the number who have to pay higher part B premiums, and expands the income relating to drug premiums.

This is a tax increase on upper income beneficiaries who have already paid more for their Medicare through payroll taxes.

I feel it's designed to convert Medicare from a program that covers all seniors to one which only covers those without other options, and leads us further down the road to privatizing Medicare as we lose the support of upper income Americans who may begin to view Medicare as a social program rather than a general insurance entitlement.

The President has also proposed to, in my opinion, reduce the amount of employer-based health benefits that 160 million Americans now enjoy.

With his tax changes, employers would be inclined to drop coverage and employees would basically be given a voucher and left to find coverage in the expensive, unfair, and often unavailable individual health marketplace, health insurance marketplace.

The voucher would be worth as much as six times more for high-wage earners than low-wage earners who will only get about 1,100 bucks in value.

In addition to that, because the proposal lowers annual income, it would decrease low-wage workers' Social Security benefits by as much as one-third when they retire.

I'm not sure this was an intended consequence, but it certainly wouldn't be a very popular feature.

The President's own analysts predict that only 3 million of the 47 million uninsured would gain insurance under this proposal. That's less than 6 percent.

Millions would lose comprehensive coverage in exchange for high-deductible plans that probably would do little to help their family meet their health care needs.

If you have a history of illness, you're older, work in a line of business the insurance industry considers high-risk, or wouldn't be able to buy insurance at any price, you would be denied insurance at any price.

That could be defined as reform, but I hardly think that it's an improvement.

The President proposes cuts to Medicaid. I know that's not entirely our jurisdiction, but his plan allows States to use Medicaid funds to expand coverage, and it seems to me that—or it doesn't allow them to do it, and you can't have it both ways.

We spend 3.7 billion more for health savings accounts which benefit, generally, upper-income families, and we think only about 100,000 of those policies exist, and we short-change the State Children's Health Insurance Program (SCHIP) program that covers more than 6 million children by at least $12 million.

I only use those figures to illustrate that we are helping precious few people, and we are not using any of these savings to help those most at need.

So, that's why I believe we're going to have to set aside this budget and wait and see what our budget Committee comes up with, and wait and see what Mr. Camp and I can negotiate, and come back to you after we've started from scratch and put forward something that I think both sides of the aisle on this Committee can agree on.

Maybe Mr. Camp has already decided that, in which case I'll recognize him to lay out a fair program for us.

[The prepared statement of Chairman Stark follows:]

Prepared Statement of The Honorable Fortney Pete Stark a Representative in Congress from the State of California

This is the first hearing before our Subcommittee since our recent reorganization. I look forward to working closely with Dave Camp as our Ranking Member. And, I'd like to welcome the new members to our Subcommittee: Reps. Xavier Becerra, Earl Pomeroy, and Stephanie Tubbs-Jones are new to our Subcommittee, though not the Committee. Rep. Kind joins us on the Subcommittee as a new Member of the Ways and Means Committee as well. Of course, welcome back to all the seasoned veterans as well. Now, to get to the subject before us.

Ms. Norwalk, thank you for appearing for our first hearing. I know it won't come as a surprise that I am disappointed by the President's budget. There is clearly a wide gulf between Congress and the Administration's priorities for health care.

From 1984–1995, Members of Congress and various Republican administrations would disagree on how to split reimbursements between rural and urban providers, or what percentage to take off of market basket updates. But, we all worked toward the same goal: preserving and improving Medicare as a guaranteed benefit for America's seniors and people with disabilities.

Instead of renewing this spirit, the President's budget guts some $300 billion out of Medicare and Medicaid over the next decade while leaving some $50 billion in overpayments to private plans in place. Even worse, this budget enhances provisions inserted into law as part of the Republican prescription drug program that hasten Medicare's demise.

First, the President loads the so-called "45% trigger" with real ammunition. Rather than recommending legislation to Congress, the President would be empowered to make across-the-board automatic Medicare cuts to limit government spending. This is a sure path to achieve the goal for Medicare to "wither on the vine."

Second, the President's budget increases the number of people who will have to pay higher Part B premiums, and expands that income-relating to Part D drug premiums. This is a tax increase on upper income beneficiaries who have already paid more for Medicare through payroll taxes. It is designed to convert Medicare from a program that covers all seniors to one which covers only those without other options—another way to privatize Medicare.

In addition to the changes in Medicare, the President has proposed to undermine employer-based health benefits where 160 million Americans get their health insurance today. Instead, employees will be given a voucher and left to find coverage in the broken, unfair, expensive individual health insurance marketplace. The voucher will be worth as much as six times more for high wage earners than lower wage workers who will get only about $1100. Then, as a kicker, because the proposal lowers annual income, it also would decrease low-wage workers' Social Security benefits by as much as one-third when they retire.

Even the President's own analysts predict that only 3 million of the 47 million uninsured would gain "insurance" under this proposal—less than 6%. Millions would lose comprehensive coverage in exchange for high deductible plans that do little to help them meet their families' health needs. If you have a history of illness, are older, or work in a line of business the insurance industry considers high risk, you won't be able to buy insurance at any price. This certainly could be defined as health "reform," *but it's not* an improvement.

Next, the President proposes cuts to Medicaid that weaken the health care safety net. These cuts undermine the President's plans to allow states to use Medicaid funds to expand coverage. You can't have it both ways.

Meanwhile, the President spends $3.7 billion more for health savings account expansions—which benefit upper income families and only 100,000 have been sold—while shortchanging the SCHIP program which covers more than 6 million children by at least $12 billion—and that's just the bare minimum needed to maintain coverage for those low-income children who have it today. If the President's SCHIP plan were enacted, states would have to cut children off their insurance. This is not the way to help the 8 million and increasing number of children without health insurance.

Secretary Leavitt said at a hearing before us last week that Medicare and Social Security have made the most significant contributions to society of any public program. I agree. That's why I believe we should set aside the President's budget and start from scratch.

Mr. CAMP. Thank you, Mr. Chairman, and welcome, Administrator Norwalk.

I hope today's hearing will be not our last opportunity for this Subcommittee to look at what we need to do to strengthen and improve the Medicare Program, and obviously, absent any changes, Medicare will not be able to keep up with the challenges that will face it in coming years.

We're all familiar with the problems plaguing the program—ever-increasing payments to hospital and other providers, beneficiary premiums that have nearly doubled in the past five years, and the hospital trust fund will run out of funds in 2018.

Identifying the problems is the easy part. The real challenge lies in finding solutions that we can work toward to strengthen and improve the Medicare Program, and far from being perfect, the Medicare proposals in the President's budget do deserve examination, and I believe are an important step in addressing these problems.

Like Chairman Stark, I too have concerns with some of what the President has presented, but I hope these proposals can serve as a beginning to start our discussions about what we can do to slow Medicare spending growth and to help protect Medicare beneficiaries from escalating health care costs.

So, to begin ways to strengthen the Medicare Program, we should look at the success of Medicare D. Since its inception, premiums paid by Medicare beneficiaries have declined. Ten-year projected costs of Part D are 270 billion lower than predicted just 2 years ago. Seniors are reporting satisfaction rates above 80 percent, while saving an average of $1,200 a year.

So, in light of these successes, I believe we must continue to enact reforms in traditional Medicare to ensure seniors will have access to high-quality and affordable health care for generations to come.

Thank you, and I appreciate the Chairman holding this hearing.

Chairman STARK. Why don't you go ahead and enlighten us in any way you'd like?

STATEMENT OF LESLIE V. NORWALK,
ACTING ADMINISTRATOR,
CENTERS FOR MEDICARE AND MEDICAID SERVICES

Ms. NORWALK. Thank you, Mr. Chairman.

If I might start off by expressing my condolences over the loss of Congressman Norwood. I'm sure he was an important part in the health care debate in his role as a dentist, and I know that we will all miss him, and I'm certainly sorry for all of our losses.

Chairman Stark, Representative Camp, and distinguished Members of the Subcommittee, I am pleased to be here today to discuss the proposals of the President's fiscal year 2008 budget for programs administered by the Centers for Medicare and Medicaid Services (CMS).

As you know, CMS is the largest purchaser of health care in the world. We provide health care coverage to nearly 1 million beneficiaries. That's one in every three Americans.

Medicare and Medicaid combined pay about one-third of the Nation's health expenditures and represent more than 84 percent of the Health and Human Services (HHS) budget.

Medicare outlays are expected to be $464 billion in fiscal year 2008 and the Federal portion of Medicaid outlays is projected to be $203 billion.

CMS accounts for nearly a fifth of the President's budget.

The President's Medicare budget aims to transform Medicare into a financially sustainable quality-based payment program. In the last year alone, experts ranging from the Medicare Payment Advisory Commission (MedPAC) to the Medicare Trustees, to Federal Reserve Chairman Ben Bernanke, have all underscored the importance of taking actions now to address Medicare's long-term financial challenges.

Specifically, MedPAC cautioned in its March 2006 report to Congress that, quote, "even if policymakers succeed at moving providers toward greater efficiency, they may still need to make other policy changes to help ensure that that program's financing is sustainable into the future."

The Administration takes these cautions very seriously. To promote long-term efficiency and sustainability, the budget includes a series of legislative proposals that would yield net savings to taxpayers of $4.3 billion in fiscal year 2008 alone, slow the annual rate of Medicare growth from—the rate of growth from 6.5 percent to 5.6 percent and the rate of Medicaid growth from 7.3 percent to 7.1 percent over the next 5 years.

The proposal would reduce growth in Medicare beneficiary premiums, as well.

Most importantly, these proposals increase the likelihood that future generations can enjoy the program's benefits.

Over the past 6 years, this Administration has worked hard to efficiently and effectively manage Medicare, Medicaid, and SCHIP. Together with Congress, we have made great strides improving care and coverage to millions of Americans who are now leading healthier, more productive lives.

One of the best examples of our progress is and new Medicare prescription drug benefit. Just 1 year since its inception, more than 90 percent of people with Medicare have coverage for prescription drugs. More than 10 million are low-income beneficiaries who are receiving comprehensive coverage with low or zero premiums and nominal cost sharing.

Beneficiary satisfaction with the benefit is high, and costs are significantly lower than originally projected.

Since last year's mid-session review, projected payments to Part D plans for the 10-year period 2007 to 2016 have dropped by $113 billion and that's due to better competition and plan bids.

The estimated average beneficiary premium for basic benefits is now $22 per month. That's 42 percent lower than the original projections when the Medicare Modernization Act (MMA) (P.L. 108–173) was originally passed.

To further illustrate the success of the Medicare Program, Medicare Advantage is providing valuable assistance to millions of seniors.

Specifically, on average, in 2006, beneficiaries enrolled in Medicare Advantage plans saved about $82 a month in out-of-pocket expenses and are expected to save even more in 2007.

Ensuring the sustainability of the Medicare Program is CMS's highest priority.

Several additional ways we are working to achieve this goal include revising how we pay for post-acute care services across different settings, expanding the successful competitive acquisition policy to include clinical lab services, and pay-for-performance expansions.

We are proposing a hospital payment increase of 3.25 percent, which is larger than the historical average, but just marginally lower than the expected market basket update of 3.9 percent. This would result in a larger update than the historical 10-year average of the 63 percent of market basket that hospitals have enjoyed over the past 10 years.

We proposed other changes that slow the rate of growth in Medicare providers, including Medicare Advantage plans.

Our proposed payment changes under part A and B have significantly impact on the Medicare Advantage program. The interaction of the proposals for Parts A and B payments would reduce the Medicare Advantage benchmarks by $15.2 billion over 5 years.

It cannot be stressed enough that program and policy changes are critical to maintaining benefits for years to come.

Under current law, and based on the budget's economic assumptions, the trust fund assets to fund Medicare Part A benefits would expire in 2018. The President's budget proposals extend the life of the hospital insurance trust fund for an additional 4 years.

In addition to Medicare and Medicaid, CMS also administers another critical program, SCHIP. The SCHIP program provides access to health care benefits to over 6 million uninsured low-income children. We are looking forward to working with Congress to get this important program reauthorized.

Finally, I'd like to quickly highlight a critical budget recommendation that would help ensure access to affordable basic private health insurance for all Americans. That's the affordable choices initiative.

This initiative would make resources available for States to help people with poor health or limited incomes purchase insurance. It also would help the non-group insurance market become more robust so people of all incomes and health status have access to affordable health insurance without regard to whether the employee provides it.

Individuals will benefit now only from improved health care, but also from the peace of mind that comes with knowing that health insurance needs will be covered. Furthermore, the health care community will benefit from the expansion of the insured population.

In closing, CMS is committed to working with Congress on continued improvements to Medicare and Medicaid and SCHIP, through innovation, modernization, and we can make both Medicare and Medicaid programs stronger.

Steps taken now, or not taken, to adopt rational, responsible, and sustainable policies will directly impact our ability to preserve the promise of health care coverage for American seniors, people with disabilities, and other vulnerable populations.

Thank you, and I'm happy to answer questions you might have and look forward to working with you on these difficult budget issues.

[The prepared statement of Ms. Norwalk follows:]

Prepared Statement of Leslie V. Norwalk, Acting Administrator Centers for Medicare and Medicaid Services

Good afternoon Chairman Stark, Representative Camp, and distinguished members of the Subcommittee. I am pleased to be here today to discuss proposals in the President's fiscal year (FY) 2008 Budget related to programs administered by the Centers for Medicare & Medicaid Services (CMS): Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP). I also would like to highlight the President's proposed Affordable Choices initiative and health care tax proposal aimed at making insurance coverage more accessible and affordable for all Americans.

For the past 6 years, this Administration has worked to manage Medicare, Medicaid and SCHIP efficiently and effectively. Together with Congress, we have made great strides in modernizing and improving health care benefits, with millions of Americans now living healthier, fuller lives. Perhaps the best example of such improvements is the Medicare prescription drug benefit (Part D) enacted by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Available to beneficiaries for the first time in January 2006, the program has been a resounding success. At last count, more than 90 percent of people with Medicare now have coverage for prescription drugs from Part D or another source, including almost 10 million low-income beneficiaries receiving comprehensive coverage with low or zero premiums and nominal cost-sharing. Beneficiary satisfaction with Part D is consistently at 75 percent or more, reaching above 90 percent for low-income beneficiaries receiving extra help.[1]

Strong enrollment and beneficiary satisfaction are just two aspects of the Part D success story, however. Equally important, Part D premiums and estimated program costs have been declining steadily thanks in part to competition among plans, smart choices by beneficiaries, and lower-than-expected growth in prescription drug spending. Since last year's mid-session review, projected payments to Part D plans for the ten-year period 2007–2016 have dropped by $113 billion, of which $96 billion is directly attributable to competition and lower plan bids. The average beneficiary premium for basic benefits is now estimated to be around $22 per month, down from $23 in 2006 and 42 percent lower than the original projection.

We also are seeing exciting trends in the Medicare Advantage program. Through Medicare Advantage, beneficiaries have access to integrated health and prescription drug benefits, often with lower premiums and cost-sharing than under fee-for-service Medicare. Medicare Advantage is a particularly important program for lower-income Medicare beneficiaries, who might otherwise struggle with Medicare's cost-sharing or supplemental insurance premiums that can be costly. Fifty-seven percent of beneficiaries enrolled in Medicare Advantage report income between $10,000 and 30,000 compared to 46 percent of fee-for-service beneficiaries.[2] Racial and ethnic minorities also benefit from the Medicare Advantage program; minorities represent 27 percent of total Medicare Advantage enrollment, compared with 20 percent in fee-for-service.[3] Enrollment in Medicare health plans has now reached an all-time high of 8.3 million beneficiaries, up from 5.3 million in 2003.

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[1] KRC Research survey for the Medicare Rx Education Network, conducted September 1–7, 2006.

[2] CMS analyzed the 2005 Medicare Current Beneficiary Survey (MCBS) to determine low-income and minority enrollment in Medicare health plans and in fee-for-service.

[3] CMS analysis of 2005 MCBS data.

SCHIP also has been a great success since its enactment. SCHIP generally targets Medicaid-ineligible uninsured children who are under 19 years old from families with incomes at or below 200 percent of the federal poverty level. States have a high degree of flexibility in designing their programs. Every state, the District of Columbia, and all five territories have had approved SCHIP plans since September 1999.

In FY 1998, the first year of SCHIP, 980,000 children were enrolled for at least part of the year. According to the latest data available from the states, by FY 2006 SCHIP enrollment of children had increased substantially, with 6.6 million children covered for at least part of the year. When combined with Medicaid, a total of 36.1 million low-income children received coverage for at least part of 2006. We look forward to working with Congress to reauthorize SCHIP this year.

FY 2008 Budget Proposals

The President's FY 2008 budget offers a plan for building on past successes to further modernize the Medicare and Medicaid programs and secure their long-term future. Growth in net Medicare spending is approaching 7 percent per year over the next five years and is even higher over ten. Working closely with beneficiaries and providers, we believe we can improve the quality, efficiency and ultimate viability of the Medicare program.

The Budget also proposes important steps to preserve and expand access to health insurance coverage for low-income children and other vulnerable Americans. SCHIP reauthorization, the President's proposal to equalize the tax treatment of health insurance received through an employer or purchased in the non-group market, the President's Affordable Choices initiative and other proposed insurance market reforms would make health insurance more affordable and accessible for millions of Americans, enabling them to live healthier, more productive lives.

Medicare Initiatives

Over the past six years, the Administration has made significant strides to promote greater quality and value in the Medicare program. The President's FY 2008 Budget would build upon these efforts, helping to transform Medicare into a quality-based payment program and improving its financial sustainability.

Federal Reserve Chairman Ben Bernanke, the Medicare Trustees, and the Medicare Payment Advisory Commission (MedPAC) all have underscored the importance of taking action *now* to address Medicare's long-term financial challenges. Testifying before the Senate Budget Committee on January 18, 2007, Chairman Bernanke stated "if early and meaningful action is not taken, the U.S. economy could be seriously weakened, with future generations bearing much of the cost." Similarly, after discussing "serious concerns" with Medicare's financial outlook, the Medicare Trustees cautioned in 2006: "We believe that prompt, effective, and decisive action is necessary to address both the exhaustion of the HI [Hospital Insurance] trust fund and anticipated rapid growth in [Medicare] expenditures."[4] Finally, in its March 2006 Report to Congress on Medicare Payment Policy, MedPAC suggested a number of strategies to address Medicare's long-term sustainability: constraining payment rates for health care providers, rationalizing benefits, increasing the program's financing, and encouraging greater efficiency from health care providers. Concluding that increasing efficiency is most desirable, MedPAC cautioned: "[e]ven if policymakers succeed at moving providers toward greater efficiency, they may still need to make other policy changes to help ensure that the program's financing is sustainable into the future."[5]

Recognizing the gravity of these warnings, the President's Budget strives to induce providers toward greater efficiency with payment policies that increase the role of competition and create a strong financial incentive for providers to slow cost growth through greater productivity and other improvements in efficiency. In addition to encouraging appropriate, high-quality care for people with Medicare, the proposals would reduce the growth in premiums for most beneficiaries. Under current law, and based on the Budget economic assumptions, the assets of the HI trust fund would start to decline in 2015; the Budget proposals would reverse that decline and increase the value of the HI Trust Fund throughout the ten-year window.

When combined with Medicare administrative proposals,[6] the FY 2008 Medicare legislative proposals, including those described below, would save $5.3 billion in FY

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[4] 2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds at pp. 3–4.

[5] Report to the Congress: Medicare Payment Policy at pp. xv; 6–8 (March 2006).

[6] The Medicare budget assumes administrative savings of $1.0 billion in FY 2008 and $10.2 billion over five years. Savings will result from new efforts to strengthen program integrity in Medicare payment systems, correct for inappropriate provider payments, and adjust payments to encourage efficiency and productivity.

2008 and $75.9 billion over five years.[7] The net effect is a reduction of less than one percent in the rate of growth for Medicare over the five-year budget window. Medicare's current average annual growth rate over the next five years is projected at 6.5 percent per year. Under the President's Budget, that rate of growth would slow to 5.6 percent per year. Specifically, the Budget would:

- *Foster Productivity and Efficiency:* Responds to inefficient health care delivery and rapid spending growth with provider payment adjustments that would account for expected productivity gains and induce providers to achieve efficiencies that restrain costs;
- *Rationalize Medicare Payment and Subsidies:* Ties payment to reporting of medical errors and expands value-based purchasing for hospitals; encourages appropriate payment for five common post-acute care conditions; addresses excessive Medicare payment and beneficiary coinsurance for power wheelchairs and oxygen equipment;
- *Improve Program Integrity:* Facilitates proper coordination of benefits through improved data sharing; creates incentives for providers to recoup their debts; strengthens the integrity of the administrative appeals process by limiting Mandamus jurisdiction as a basis for obtaining judicial review;
- *Increase High-Income Beneficiary Responsibility for Health Care:* Eliminates annual indexing of income thresholds for reduced Part B premium subsidies, and extends the income-related Part B premium adjustment to Part D premiums; and
- *Improve Long-Term Sustainability:* As a fall-back response if there is no Congressional action, applies a −0.4 percent sequester to the Medicare payment amount for all providers in the first year that general revenue funding for the Medicare program exceeds 45 percent. The sequester reduction would grow by an additional 0.4 percent in each successive year that the general revenue funding remained above 45 percent.

A table of all Medicare legislative and administrative proposals included in the Budget along with budget impacts is included as Attachment A. The entire HHS *Budget in Brief* is available online http://www.hhs.gov/budget/08budget/2008BudgetInBrief.pdf

Medicaid Initiatives

Many of the most vulnerable Medicare beneficiaries also rely on Medicaid for help with Medicare premiums and other cost-sharing, and additional benefits. In 2006, 4.9 million Medicaid enrollees were aged 65 and over; an additional 8.3 million were blind and disabled. Collectively, these groups accounted for more than 25 percent of total Medicaid enrollment in 2006. The President's Budget makes a number of proposals to preserve and strengthen the Medicaid program, building on past efforts to create service efficiencies and to assure its fiscal integrity. Even with these changes, the Medicaid baseline continues to grow at an average annual rate of more than seven percent, exceeding the increase in Federal and State budget revenues.

In FY 2008, we are proposing a series of legislative changes that will result in gross changes of $12 billion over the next five years, which will keep Medicaid up-to-date and sustainable for years to come. The President's FY 2008 Medicaid reform proposals would slow the average annual growth rate in Medicaid over the next five years from 7.3 percent per year to 7.1 percent per year.

Access Initiatives

In addition to taking steps towards securing the future of Medicare and Medicaid, the President's Budget demonstrates commitment to preserving and expanding health insurance coverage for all Americans. When it comes to health care, the tax code is biased in favor of individuals who receive insurance from their employers. To remove this inequality, the President proposes replacing the existing—and unlimited—exclusion for employer-sponsored insurance with a flat deduction for those with at least catastrophic health insurance. As long as a family has at least a catastrophic health insurance policy, they will be able to deduct the first $15,000 from their income ($7,500 for an individual), regardless of whether they receive their health insurance policy from their employer or purchase it in the non-group market. This will foster a true marketplace for health care, encourage competition, improve the efficiency of the system, and reduce the ranks of the uninsured.

The Federal Government's current system of paying for health care results in billions of dollars being spent inefficiently through a patchwork of subsidies and pay-

[7] The savings estimates are net of a proposal in which Medicare funds are transferred to Medicaid to pay premiums for certain low-income individuals.

ments to providers. In addition to directly funding the care provided to people enrolled in programs like Medicare and Medicaid, health care entitlement programs finance payments to institutions that either indirectly pay for uncompensated care or subsidize their operating expenses.

The health care system could operate more efficiently if some portion of institutional payments instead were redirected to help people with poor health or limited income afford health insurance. The uninsured often use emergency rooms as a source of primary care, which leads to suboptimal care and spending outcomes. If this public spending were focused on helping the uninsured purchase private insurance, people would receive the care they need in the most appropriate setting. The health care system needs to be transformed in a way that avoids costly and unnecessary medical visits and emphasizes upfront, affordable private health insurance options.

This transformation could happen by subsidizing the purchase of private insurance for low-income individuals. However, any such health care reforms would need to be State-based and budget neutral, not create a new entitlement and not affect savings contained in the President's Budget that are necessary to address the unsustainable growth of Federal entitlement programs. The Federal Government would also maintain its commitment to the neediest and most vulnerable populations, while acknowledging that States are best situated to craft innovative solutions to move people into affordable insurance. The Secretary of HHS will be working with Congress and the States in the upcoming year to achieve health care marketplace reforms, called "Affordable Choices."

The Administration also is committed to working with Congress to reauthorize the SCHIP program this year. SCHIP has provided $40 billion over the last ten years to states to provide health care coverage to low-income, uninsured children who are not eligible for Medicaid. Specifically, the Budget proposes to:

- Reauthorize SCHIP for five years;
- Increase funding by approximately $5 billion ($4.8) over the next five years;
- Redirect approximately $4 billion in unexpended funds—taken together with the increase in funding, nearly $9 billion will be made available for the program, enough to meet projected demand for targeted enrollment in fiscal year 2008; and
- Refocus the program on low-income, uninsured children and pregnant women in families with incomes at or below 200 percent of the federal poverty level, as Congress originally intended.

Conclusion

Experience with Medicare Part D to date demonstrates the great potential of market reforms to save Medicare dollars, while also promoting beneficiary choice and satisfaction. Moreover, greater flexibility for states under the Medicaid program has allowed reductions in cost growth, without significant benefit compromises. Through continued innovation and modernizations such as these, we can make the Medicare and Medicaid programs even stronger. Continuing on this path is critical.

The President's FY 2008 Budget demonstrates a real commitment to improving America's health care system by further modernizing and improving Medicare and Medicaid; strengthening health care coverage for low-income and vulnerable populations; and taking steps to make health care more affordable and accessible for all. This is a critical time in the life of Medicare and Medicaid. Steps taken now—or not taken—to adopt rational, responsible, and sustainable policies will directly impact our ability to preserve the promise of health care coverage for America's seniors, people with disabilities, and low-income, vulnerable populations. We look forward to working with Congress in the coming year to reauthorize SCHIP, strengthen our existing programs, and improve access to affordable health insurance for all Americans.

Chairman STARK. Thank you.

I'm going to ask for some information that we have previously been unable to get from CMS, but I know that you've mentioned to me in testimony the, quote, "extra benefits" of Medicare Advantage plans, and I wonder, if I picked three areas of the country, a rural plan, because people talk to me about how we've got these plans in rural areas, and say one in New York, and one in Los An-

geles or one in Florida, and we have not been able to get a list from you of the extra benefits that these plans are supposedly providing.

I'm willing to guess or bet that the extra benefits come nowhere near having a value of the overpayment, i.e., that amount above 95 or even 100 percent of fee-for-service in those areas.

I'd really appreciate it if you would ask your staff to quantify that for us.

[The information follows:]

> In 2007, enrollees in MA plans are receiving, on average, additional benefits with a value of $86 per month. Plans provide an average of about $108 in additional benefits; primarily cost sharing and premium buy-downs, as well as specific benefits such as routine vision and dental care. Plans charge, on average, a monthly premium of about $22 for these benefits, yielding a net average value for enrollees of $86 per month.
>
> For example, in Fremont, California, a beneficiary between the ages of 65 and 69 in poor health has access to a $0 premium plan that offers: $10 copay for plan doctors, unlike Original Medicare which generally charges 20% coinsurance for most doctor services; a $3000 out-of-pocket limit for A/B benefits, providing peace of mind in knowing that catastrophic expenses will be covered; enhanced drug coverage with a $0 deductible and generic gap coverage for no additional premium; and vision services and physical exams not covered under Original Medicare.
>
> As another example, in Tampa, Florida, a beneficiary between the ages of 65 and 69 in poor health has access to a $0 premium plan that offers: drug benefits with no deductible, free generics and generic coverage in the gap; unlimited inpatient hospital services with a $100 copay per days 1–5 of a stay instead of Original Medicare's $992 deductible and coinsurance for stays beyond 60 days; copays of $0–$10 for plan doctors with no deductible instead of Original Medicare's $131 deductible and 20% coinsurance; and preventive dental services not covered under Original Medicare.

I further—I don't know whether—somebody hit me here. My clock doesn't seem to be running, either, so I'll run over if you don't nudge me.

I'll give you an example.

A major Medicare Advantage plan in my district charges a $99-a-month premium. Okay? That's on top of a 93.50 Part B premium.

In that plan, if you're hospitalized, you're charged 275 bucks a day for the first 10 days. That's $2,750 out of your own pocket.

Now, if that person had been in traditional Medicare, they'd pay a single deductible of 992. That's far less than half.

I think that in many cases, that these Medicare Advantage plans may not come anywhere close to providing extra benefits. Eyeglasses are worth a couple hundred bucks, I suppose, a year. We can buy that now, I think, as Federal employees, if we want to get a insurance extra.

I really think—and I have no quarrel with these plans if I thought they weren't draining funds away from CMS that we could use for SCHIP or other good things, and I think it's incumbent on us to make sure that our constituents are getting a bargain and aren't getting oversold for the accessories, the white walls and the Kleenex dispensers, at the risk of getting the decent automobile that we'd like them to get.

So, that I'd like to see some more—and I don't know if there's a competitive reason, and if that information is, for some reason, secret, or a trade secret, I'd be happy to see it sanitized, but I do think that we've heard this in general. We're pretty sure, because you've heard it from MedPAC, as have we, that we are over-paying the Medicare Advantage plans.

That doesn't come as any news to you, does it?

Ms. NORWALK. I might characterize it a bit differently, but——

Chairman STARK. Okay, but MedPAC has suggested—now, I'm just saying that they are the one group who stands out, not having contributed anything, and we're going to—Mr. Camp and I are going to have to talk to all those doctors out there who haven't got a fix for their payment system, and all those hospitals in New York City and in Oops, North Dakota, and wherever else, just to make sure—and in Texas, I got a hospital that's upset with me—Baylor, I think, a little hospital down there someplace in Texas there, Sam?

Mr. JOHNSON. Baylor.

Chairman STARK. Yes. They all want to know why they're going to get cut.

I think that we're going to have answer for that, and I hope decide within this Committee how we're going to adjust those cuts, and the Medicare Advantage plans look like they've kind of been left out of the loop, and I don't want them to feel that we're overlooking them in our efforts.

Mr. Camp, why don't you make some suggestions on how we're going to solve these—he's going to tell us how we're going to solve the physician reimbursement——

Mr. CAMP. I wish I had that answer.

Just briefly on the Medicare Advantage, can you just sort of highlight what they do?

Ms. NORWALK. If I can make about five different points. Let me run through what those five are.

The first is the fee for service impacts and how the fee-for-service payment changes impact the Medicare Advantage program, because they do.

Budget neutrality adjustment changes that we've been making already, which continue to go into effect over the next years, the better benefits, let me run through a couple of what those are, and our actuaries provide this $86 projection for 2007, and we can get you that information.

Then generally, the populations that are particularly advantaged through the Medicare Advantage program.

The first point, the fee for service impacts. Our changes to Parts A and B, the proposed changes that we make do have a significant impact on the Medicare Advantage program benchmarks.

Given how the benchmarks are determined, Medicare Advantage payments would be reduced $15.2 billion over five years, so they actually not spared. They may not have been specifically addressed in the budget proposals, but they are not spared the impact, mainly because of the interactions and how we determine the payment rates that go to Medicare Advantage plans.

In addition, in 2007, we made a $2.3 billion adjustment to plans because of budget neutrality, something that was passed in the Balanced Budget Act, and that we're phasing out.

To address more specifically your point, Mr. Chairman, on the better benefits, 86 percent of beneficiaries have access to zero premium plans for Part C and Part D, so they don't pay any additional premium, and all States except for Alaska have at least one Medi-

care plan with a drug benefit that doesn't have a—has no Part D premium, so that's one advantage.

Another is gap coverage. Forty-one States have at least one plan that has no coverage gap at all.

Hospitalization. More than 80 percent provide coverage for hospital stays beyond the original Medicare benefit and coverage of ER and post-stabilization care for emergencies occurring outside of the country.

Vision and hearing. You mentioned glasses. More than 75 percent cover routine eye care and hearing tests. More than 60 percent have coverage for hearing aids and 64 percent have coverage for eyeglasess.

For physical exams, while there is a welcome to Medicare physical for the first 6 months, over 90 percent of Medicare Advantage plans cover a routine physical without regard to your age or where you are in the Medicare Program.

In non-Medicare-covered stays in a skilled nursing facility, more than 90 percent do not require a 3-day stay before a skilled nursing stay is covered.

So, all of these things, and we've got some specifics from our office of the actuary, who determined the $86 savings per month, and we'll be happy to share that with you. I don't know if we've got the rural, Los Angeles, and New York or Florida plans, but we'll put together some information there, too.

Mr. CAMP. I'll be happy to yield.

Chairman STARK. I would just—my question there was not the $86 savings necessarily to the beneficiary, but I'm just trying to get a dollar value on a plan.

Let's say it offers vision and hearing, and saves some people some money and doesn't have a doughnut hole or something like that, but how much more is the Government paying for those benefits or in the, quote, "overpayment"?

Ms. NORWALK. The way that the Medicare Advantage payments are structured under the statute is a couple of things happen.

First of all, the statute sets forth something called benchmarks, and these are determined often based on historical practices—a rural floor, an urban floor, a percentage increase from fee-for-service or from the final year, and then 100 percent of fee for service.

What the plans do is, the plans come in with a bid, and the plan bids are actually just around the cost for Part A and part B. They're very similar to that.

The statutory benchmarks, often there is a difference, and I think this is that what you call an overpayment, I don't characterize it as such, and let me tell you why I don't.

Any money that is spent between that benchmark that's statutorily determined in the plan bid, it's also statutorily described where that money goes.

Twenty-five percent of that difference goes back to the Federal treasury, and 75 percent of it is returned to beneficiaries in the form of additional benefits, as opposed to going into the pockets of the plan.

That is part of the reason I think why beneficiaries see such comprehensive benefit packages, at least more comprehensive than the

original Medicare Program and some of the things that I outlined here.

Now, in terms of who it helps, from a disproportionate perspective, we see that more minorities as a percentage are in the Medicare Advantage plan and so are more low-income beneficiaries, so we think that it particularly helps those minorities and low-income beneficiaries who really need these additional benefits and who could use that extra money in their pocket to provide them with better health care coverage.

Mr. CAMP. If I might reclaim my time, I appreciate the macro approach, but I think what the Chairman is asking is an individual basis, and if you could submit maybe later to the Committee some of that information on what individuals face as they receive these plans.

I just want to get one quick point in, and get your thoughts on the physician formula.

I think there are steps the Administration could take to help us solve this very difficult issue. Obviously, we've had a number of updates and sort of had a very checkered past on that, but removing prescription drugs from the physician formula is something that would, both retrospectively and prospectively, would really help us fix the problem.

Can you comment on why the Administration has not removed drugs from the Surgeon General's Report (SGR) to this date and what other steps might the Administration take to help Congress and physicians finally overcome this growing problem?

Ms. NORWALK. Yes. The budget does recognize that this has been a problem ever since I have been at CMS, nearly 6 years now, and it is certainly continuing to be an issue.

We would like Medicare to move from a passive payer to be more of an active purchaser, and we very much look forward to the changes or to the recommendations that MedPAC is going to be making in the next few weeks, and have been reading their testimony very carefully.

In terms of the specific questions around the SGR and drugs, for example, we took a very close look, and the legal analysis told us that we could not take it out retrospectively.

Taking out the drugs for the SGR on a prospective basis really doesn't solve the problem in 2008–2009. In fact, I don't think it even begins to dent the problem for years out. It's something that we'd be willing to talk with you about, but from a retrospective basis, that has been my understanding the entire time that I've been at CMS.

We do think that a change in incentives is very important. I know that when Mark Miller, who is the executive director of MedPAC, testified last June, he talked about volume and intensity of services.

The way that the SGR formula is currently characterized doesn't do much to incentivize an individual physician. In fact, you could argue that the current formula is a disincentive, because physicians want to be able to earn enough money. So, we don't really reward efficient behavior of physicians.

In working with MedPAC, working with Members of Congress, and working with the specialty societies, I think it's going to be a

critical thing that we do over the coming months, so that we can look at the bigger picture and address these issues on a go-forward basis.

Mr. CAMP. All right. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Thank you, and thank you for yielding.

Mr. Doggett would like to inquire.

Mr. DOGGETT. Thank you, Mr. Chairman, and thank you, Ms. Norwalk.

As you know, I have been among many Members of Congress who have expressed concern on the Part D program concerning extra help.

The first question I have for you, though, really relates more generally to the question of the non-responsiveness of your agency, and I understand you're the acting administrator, and you were not the administrator when we had the last hearing on Part D.

As you know, 146 Members of Congress sent a short inquiry about the low-income or extra help program to the agency in May. We did not receive any response, despite repeated attempts to get one, until October.

Eleven Members of this Committee, including the now Chairman, Mr. Rangel, because we got so little information at the hearing itself has June, sent a list of questions to the agency in June which the agency did not bother to answer until shortly before your testimony today in January.

Can we count on more responsiveness from the agency this year on questions, whether they're about the extra help program or some other aspect of the jurisdiction of this Committee?

Ms. NORWALK. Absolutely. I think it's very important that we be responsive, wherever it is that it's permissible and so forth. So, absolutely should be more responsive.

Mr. DOGGETT. I hope that will happen.

Even if we find areas of policy disagreement, just being able to get a straight answer in a timely fashion is really important to our work.

Specifically, on those seniors who are entitled to extra help, that is, free prescriptions, or almost free prescriptions because of their condition, how many of those people have not been signed up in any kind of prescription drug program as of today?

Ms. NORWALK. We estimate 3.25 million beneficiaries who are low-income have not signed up as of today.

Mr. DOGGETT. Those tend to be some of our poorest seniors who, when this proposal or drug program was originally proposed, were identified as the ones who most needed help.

Ms. NORWALK. Absolutely.

Mr. DOGGETT. As you know, the inspector general has called for new legislation to empower you, and you addressed that in a letter you responded to me this week.

Do you know, does anyone at the center know the names of the individuals that are among that 3.25 million?

Ms. NORWALK. We know the names of the individuals who haven't signed up for the benefit, because we know the names of all Medicare beneficiaries, and we estimate, of the—we probably don't know precisely——

Mr. DOGGETT. You don't have the names of the 3.25 million people——

Ms. NORWALK. No.

Mr. DOGGETT [continuing]. That you just identified?

Ms. NORWALK. We probably have some subset of those, mainly because they've lost their Liability Insurance Supplement (LIS), many of them will have lost their LIS coverage last year, but I don't think that we have 3.25 million names that I could hand you.

Mr. DOGGETT. In these belated responses that you send to us, you have referred to your efforts to get these people Medicare coverage as data-driven.

It would seem to me that the names of the people entitled to get the extra help would be at the top of the data-drive list.

Ms. NORWALK. Absolutely.

Part of that relates to the individuals who may have creditable coverage that, just in terms of the number of populations and the interactions, so while I suspect we have a fair number of them and we need to do as much data-driven as possible, we've provided a grant to the National Council on Aging to help us identify and make sure that we do very targeted outreach, but I totally agree with your premise that this is a group that we can hardly do enough to reach out to, and we need to make sure that all of our resources, combined resources—I'm more than happy to do events with you or family any Member of this Committee to ensure that we can reach out to them.

Mr. DOGGETT. Well, I guess, while I'm sure more events are always helpful, my concern is that the center continues to do the same thing that has been unsuccessful in getting these 3.25 million people in the past.

When Chairman Rangel sent the letter on behalf of a number of us last June, one of the questions that he asked was whether CMS would require the plans to do the enrollment, would require a checkoff and ask the plans to refer beneficiaries to extra help by screening them and advising them about this in the enrollment materials.

The answer that came back was that CMS would not require that.

Why is that?

Ms. NORWALK. Well, I don't think we have the statutory authority to require it, but I frankly think it's a very good idea not only that plans have an incentive to enroll these beneficiaries because they get payments directly from the Federal Government for the most part, rather than from the beneficiary in terms of paying premiums, so consequently——

Mr. DOGGETT. Do you think that legislation to authorize doing that would be helpful?

Ms. NORWALK. I'd like to talk to the plans about it first, because I suspect that many of them are doing it on their own, and if they're not, we could certainly recommend it to them,

Before we go ahead and open up the Part D program, which I think is, as a general rule, working quite well, if we can do things on a collaborative basis, which we often do, I think that would be a good approach.

Mr. DOGGETT. The Internal Revenue Service, as the inspector general noted, does have information, certainly not on a poor senior who doesn't file a tax return, but would have the names of some of these 3.25 million people; do they not?

Ms. NORWALK. Well, it really depends how many of the 3.25 million file taxes, and given that under the current LIS program in terms of the setup, Social Security payments are included on our side and not included on the tax side, so we think that probably not a whole lot of them, and certainly we're looking at ways to get people identified and get this benefit any way possible.

I'm not sure if that is the best approach, if that's the most targeted approach, but I think it would make sense for us to work with the IRS and talk with them about the likelihood of being able to identify these people.

Mr. DOGGETT. I hope you will do that, because as you know, that's something we've asked since last May for you to do, and if you could get around to doing it now, it would be great.

Ms. NORWALK. Okay.

Mr. DOGGETT. Just one last question, related to what Mr. Stark was asking about on Medicare Advantage.

You're aware that the Commonwealth Fund has estimated that you paid under the Part D program the Medicare Advantage plans $922 more per enrollee of the 5.6 million people enrolled there, than for people under traditional Medicare.

Do you agree with that evaluation? Does that sound about right?

Ms. NORWALK. It doesn't sound about right. I don't have the study in front of me, obviously, but I'm more than happy to take a look at it and get back to you.

[The information follows:]

> I believe that the more appropriate comparison between payments to MA plans and fee-for-service payments is the costs of delivering similar benefits. When you compare plan bids for providing Medicare part A and B services with fee-for-service Medicare costs for the same services, the difference is about 3 percent. The vast proportion of the rest of the dollars go to beneficiaries in the form of lower cost-sharing, lower premiums, and additional benefits, with an average value for MA enrollees of $86 a month.
>
> This is because as the Congress set up the payment method for MA plans, 75% of any difference between plan bids and statutory benchmark amounts is required to be returned to the enrollees as extra benefits, such as lower cost sharing and premiums, in other words, benefits they don't get from traditional Medicare. So regardless of what the number might be, under the law the vast majority of these funds are used to provide extra benefits to Medicare beneficiaries.
>
> Regarding the Commonwealth study, I know we had a number of methodological issues with the analysis, one concern being that the analysis used data from 2005, which is before the competitive bidding method for paying plans went into effect. Under the bidding method, 25% of the difference between bids and benchmarks stays with the government. Further, their study would need to be updated to take into consideration the phase out of the budget neutrality adjustment, which is being phased out beginning this year.

I, from my recollection in terms of looking at it, we had some differences in opinion as to how you should calculate a number of the different payment streams and the amounts.

Mr. DOGGETT. We would welcome that.

What is your own best estimate today of how much more you pay on the average per beneficiary to Medicare Advantage plans than is the cost of traditional Medicare per beneficiary?

Ms. NORWALK. I don't have the dollar amount of benefits that go back to Medicare beneficiaries, that 75 percent, but we'll be happy to get that to you.

[The information follows:]

> Last summer MedPAC estimated a 12% difference between traditional Medicare and MA costs for 2006. As I indicated earlier, we believe it is more appropriate to compare the MA and fee-for-service costs of delivering Medicare benefits. When looked at this way, the difference is about 3 percent. And, again, most of the rest of the dollars go to provide beneficiaries with extra benefits and lower out-of-pocket costs.
>
> We also have some concerns with MedPAC's methodology. For example, they looked only at 2006, when the full budget neutrality adjustment was still being paid to plans. This adjustment is being phased out beginning this year, as required by the DRA of 2005.

Mr. DOGGETT. Thank you.

Chairman STARK. Mr. Johnson?

Mr. JOHNSON. Thank you, Mr. Stark.

Leslie, you're doing great.

Ms. NORWALK. Thanks.

Mr. JOHNSON. I'm concerned about the provisions in the Deficit Reduction Act (DRA) (P.L. 109–171) that cut the payment for imaging services. In some ways, maybe we're being penny-wise and pound-foolish.

For example, Medicare covers ultrasound guided breast biopsies in the physician's office as opposed to open surgical biopsy in the hospital.

The less invasive procedure saves money, decreases the risk of infection, and allows for faster diagnosis.

However, Medicare doesn't look at the data across services, so if the clinical practice is moving from hospital outpatient to doctor's office and saving money, our data doesn't show that. It only shows an increase in doctor utilization of ultrasound.

At a time when we're looking at ways to rethink provider payment, do you think, and don't you think it's important to have data that's aggregated across settings of care and what steps is CMS taking to get us there?

Ms. NORWALK. Yes, I generally agree with that premise, that it would be very helpful if we can look across different payment lines.

As I'm sure you're aware, because of varying budget rules, we don't offset part A, part B, C, or D. They don't offset each other if you have savings in one area or another.

We have seen, and MedPAC has recognized that imaging generally has gone through some explosive growth in the last few years, and we've been very concerned about that. I think that was one of the things that the DRA was intended to address.

Generally, as to your issue of less invasive procedures, absolutely it makes sense for us to be looking at procedures that are better, provide better quality for patients and provide better information for physicians, and I think that's something that we're more than happy to work with your office to take a look at that and see whether or not there are ways that we can look at this data across the different parts of the program to make sure——

Mr. JOHNSON. What has to happen for you to be able to do that?

Ms. NORWALK. Actually, let me go back and talk to staff, and then get back to you in terms of the specifics that we would need.

[The information follows:]

> Physicians make recommendations about what types of treatments are appropriate for different conditions and different patients. Physicians also usually hold primary responsibility for determining the settings in which the services are furnished. We agree that it is appropriate to examine the different kinds of treatments ordered by physicians and settings in which services are furnished. We are exploring comparison of the relative resource use of individual physicians, including not just the services furnished by a physician but also the services they order for entire episodes of care across given periods of time. Under such a measurement approach, physicians who order less expensive forms of diagnoses or treatments, and order diagnostic tests or treatments in less expensive settings would compare favorably to their peers. For example, a physician who ordered an ultrasound guided breast biopsy in the office setting would compare favorably to a physician who ordered an open surgical biopsy in an inpatient or outpatient setting. We look forward to applying the lessons we learn from this effort to further the process of transforming from a passive payer to an active purchaser of health care services.

In terms of budget scoring and whether or not you could, from a budget perspective actually count thing in one area or another, I suspect that there would need to be some pretty significant changes, not only within the Administration but also with Congress, in terms of how the Medicare Program looks at its overall payment costs, not just part A, but also part B.

Mr. JOHNSON. The budget also details savings you expect to derive from a demonstration program on competitive bidding for lab services.

I'm wondering what protections are going to be included in your outline that will ensure patients maintain access to critical technologies and services under a competitive bidding program.

Generally speaking, the lowest bidder happens to have the worst technology and quality of service.

Ms. NORWALK. I think we have shown in other parts of competitive bidding in the Medicare Program how important it is on the one hand to ensure that you're getting quality services and to put into place varying requirements to ensure the quality of services.

Certainly, most clinical lab services are really much more like a commodity as opposed to—a commodity rather than an individual visit with a physician, for example, and we think that because of that, there is some pretty significant opportunities for savings in the program.

I totally appreciate and agree with your general premise that we do need to ensure quality first and then look at making sure that we can get savings after that.

Mr. JOHNSON. Thank you.

Could you make a comment on Advantage plans? Are we saving any money with that?

Ms. NORWALK. I think Medicare Advantage plans provide some significant value for beneficiaries who are in them.

Before, when I was talking to, or answering Chairman Stark's question, the $86 that they get in additional benefits, I'd really like to highlight how those who are minorities and those who are low-income are those who typically are receiving the most benefits.

For the Medicare Advantage plan, the number, the percent of beneficiaries who are in them that are minority are 27 percent of Medicare Advantage, while only 20 percent were in the fee-for-service program.

In terms of those who are low-income, 57 percent of those low-income are in Medicare Advantage and 46 percent are in fee-for-service, so there's a disproportion there, and I think as we take a look at the Medicare Advantage payments, because they're already going to take some reductions because of the fee-for-service changes, we have over $15 million in 5 years, we need to also consider how this impacts the beneficiary who is receiving these services today and making sure that they can continue to have the benefits that they need as we move forward.

Mr. JOHNSON. Thank you so much.

Ms. NORWALK. Thank you.

Mr. JOHNSON. I yield back.

Chairman STARK. Thank you, Sam.

Mr. Kind. Excuse me. Mr. Pomeroy.

Mr. POMEROY. Thank you, Mr. Chairman.

Let me just express publicly my great sense of pleasure at sitting on this side of the dais with you on a health Subcommittee.

There was a time in an earlier life when I was an insurance commissioner. I sat where Administrator Norwalk now sits, as a State insurance commissioner, not as a substantial Federal official, but I like this view better.

Ms. NORWALK. Want to switch?

Mr. POMEROY. No, no. I've been on the receiving end of the Chairman's questions before.

What I've got to talk to you about involves what I think are very significant threats to rural health care delivery in light of the budget numbers undergirding Medicare.

We're seeing, for example, 69 percent of home health agencies in North Dakota at zero percent Medicare profit margin or less.

Some of the savings in Medicare in the budget anticipate a market basket reduction of .65 percent.

If you've got 69 percent at zero and you're about to reduce the market basket, it looks to me like you're going to put a lot of them under water and potentially out of business.

Delivering home health care in rural areas is tough, but the alternative of institutionalizing them is expensive and disagreeable on many other factors.

I'd like you to respond to that.

Ms. NORWALK. Well, watching out for rural providers and ensuring that beneficiaries in rural areas have access to health care is critically important, particularly because of, often, the difficulty in getting from one location to another.

In looking at how we update all providers across all sectors, I think MedPAC has a really important table in their March report to Congress that looks at whether or not current payments are adequate and what cost changes are expected to come in the coming year.

In terms of indicators, they suggest looking at beneficiary access, capacity and supply, access to capital, payments in cost, volume, and quality, and changes in economy-wide productivity and input

prices, and that that should—those factors should judge what we should do in upcoming, typically, in the upcoming year for MedPAC but for the Medicare program and the budget——

Mr. POMEROY. Let me just review. I'm not going to have time during my brief question period, I guess, to hear the whole balance of it, but just the points you've ticked off—access to health care. Well, that certainly is more challenged in a rural circumstance.

Supply, volume. Volume is really tough, because you have in these small rural areas, people aging in place——

Ms. NORWALK. Right.

Mr. POMEROY [continuing]. Very old communities compared to what would normally be a demographic of a normal small town.

Access to capital, forget about it. These are small, non-profit operations, again, operating at or below the water line with a bleaker outlook to come.

Second point. One of the things that has sustained rural health care delivery has been efforts funded through HHS to coordinate care delivery, to help promote centrally new ideas and improving efficiencies in rural health care and then getting it out to rural hospitals, providing almost a kind of a central research and development that they can't do out in the individual small institutions.

Well, those have been viciously cut in the general budget with a note that, well, enhanced reimbursements under the MMA are sure going to help that.

Can you tell us about components of Medicare reimbursements that somehow go to these centralized resource capacities serving rural hospitals?

Ms. NORWALK. Well, I think if you take a look at the MedPAC recommendations, separate and apart from just how they've done this—so if I go back just 2 seconds, if I may, for the home health piece.

Home health has had the highest—has had incredibly high margins generally, across the board. Now, I totally appreciate that often, in the rural sector, things can be different.

In terms of——

Mr. POMEROY. I told you 69 percent of them are at zero, so I don't care to hear—I'm interested, I suppose, in a casual way about the urban successes in terms of health care margins, but mine are about—mine are at zero, about to go south.

The last point I need to make. Physician reimbursements.

Do you believe that the sustainable growth rate issue resolving on a long-term basis is a priority for Medicare?

Ms. NORWALK. Absolutely.

Mr. POMEROY. Do you think that it's unfortunate that the Administration—let me put it this way. Do you believe a multi-year fix is preferable to a 1-year patch?

Ms. NORWALK. I think there is a lot involved in it, and I suspect that multi-year would be better than single-year, because in all of our payment systems, it is preferable for providers to have some certainty in payment streams from 1 year to the next, so generally, yes.

Mr. POMEROY. I agree with you. My time is up.

One of the great disappointments so far in the Committee on Ways and Means is, we are ready and willing to tackle these ques-

tions cooperatively with the President, is that the President has not offered a dime on multi-year fix to sustainable growth rate in his budget, and especially coming in the face of the other Medicare cuts, it's going to make it extraordinarily difficult to work together.

Now, the Secretary said he looks forward to working with us on this problem. Well, that's just more talk. Let's get down to it.

The President really passed on leadership here by putting a goose egg in his budget relative to multi-year fix other than a single-year patch.

Ms. NORWALK. I do think it's one of the more difficult problems that the Medicare Program has, and we look forward to working with you and with MedPAC, who will be back here in a few weeks to talk more specifically about their recommendations.

It's important of course that we continue to follow the House rules on PAYGO and making sure that beneficiary premiums don't skyrocket as a result of this fix.

So, there are a lot of different and very difficult pieces to discuss, and I——

Mr. POMEROY. How many rural representatives are on MedPAC?

Ms. NORWALK. I don't know. I'll have to get back to you on that. I'll have to ask.

Mr. POMEROY. Zero.

I think that with 25 percent of Medicare recipients living in rural areas, the under-representation of rural health care providers on MedPAC, and rural health care experts on MedPAC, is a very serious problem.

Now, the nominations I understand are selected by the comptroller general, but this is one I would direct your attention to.

Small wonder you've got the kind of MedPAC data you've got on urban health care margins and you didn't know that North Dakota, 69 percent of them are at zero.

You got to get some rural representation there.

Thank you, Mr. Chairman. I yield back.

Chairman STARK. We might impose on Ms. Norwalk to stay a few extra minutes, but I'm sorry, Earl, that I didn't indicate the time.

For the Federal employees, the Government closed at 2 o'clock because of the weather, and I don't want to keep anybody here who's got a bad commute, so I'd like to move along as quickly as we can, but we can go another round if Members would like.

Mr. English.

Mr. ENGLISH. Thank you, Mr. Chairman.

Ms. Norwalk, with any budget, the devil is in the details, and there are a number of details in this budget that I've been trying to get my arms around, and perhaps you can help me.

I noticed, and was concerned that in this budget proposal, there are cuts for Skilled Nursing Facilities (SNFs) that I think potentially could impact on quality.

For example, the SNF market basket fees alone, which the budget claims will reduce Medicare expenditures by over $1 billion, represents 23 percent of proposed Medicare savings in fiscal year 2008.

Well, the budget also notes that payments to SNFs account for only 4.8 percent of Medicare payments.

On the face of it, that would seem rather disproportionate.

In another area, I see the President's budget calls for Medicare beneficiaries to assume ownership of home oxygen equipment after 13 months as opposed to the current 36-month cap; and of course, I don't think we really know how many older citizens are going to actually manage home oxygen equipment once this is exclusively their responsibility, since this is a life-saving service for many of them.

I wonder if you would agree that it might make sense to hold off on a requirement that beneficiaries own this equipment until we see if there is a workable system that can be predicated on patient ownership.

I would also, if you would, like you to comment on the September 2006 Office of the Inspector General study entitled "Medicare Home Oxygen Cost and Servicing,"and does this provide adequate evidence to go forward?

I guess the final question, grouping them together, I've gotten feedback locally in Erie, Pennsylvania from an ambulance provider.

I've noticed that over the years they've faced significant decreases in reimbursement rates. They have been struggling for some time. Yet the Administration's budget proposes to decrease payments to ambulances by .65 percent again in fiscal year 2008.

Could you speak to the logic of that decision, and perhaps those two other policies?

Ms. NORWALK. Sure.

[The information follows:]

The President's fiscal year (FY) 2008 Budget proposes a number of provider payment reforms to help extend the life of the Medicare Trust Funds and preserve Medicare coverage for future generations. For example, in the case of home oxygen, once the beneficiary owns the equipment after 13 months (36 months for newer technology such as oxygen generating portable equipment), the Centers for Medicare & Medicaid Services (CMS) will make separate payments to support a beneficiary's use of oxygen equipment, as is the case under the current policy (i.e., after 36 months). CMS will make separate payments for general maintenance and servicing visits every 6 months, delivery and refilling of stationary and portable oxygen contents, reasonable and necessary repairs, and replacement supplies and accessories. Beneficiaries have the option of having their original or another supplier provide maintenance and servicing and repairs of their oxygen equipment.

As you reference in your question, the Department of Health and Human Services Office of Inspector General (HHS OIG) issued a report in September 2006 that provided important information on cost, servicing, and maintenance issues. The HHS OIG report recommended that CMS work with Congress to further reduce the rental period for oxygen. We agreed with their recommendation and, as you know, proposed to reduce the rental period for oxygen from 36 to 13 months.

More specifically, the HHS OIG report provided vital information on the suppliers' purchase price, reuse, and maintenance and servicing of oxygen concentrators. The OIG report found that concentrators cost about $587, on average, to purchase. The report also found that suppliers rented used concentrators to about 73 percent of the sampled beneficiaries. The used concentrators were 2.5 years old, on average, but there were cases of concentrators that were over 10 years old.

In addition, the report provided details on the maintenance and servicing that is actually done during a supplier's visit. The report found that minimal servicing and maintenance is necessary for concentrators and portable equipment. This is an important finding because the report was based not

only on reports from suppliers, but also on actual on-site observation accompanying suppliers on their visits to beneficiaries' homes. In addition, the report found that these servicing tasks take minimal time to perform. More specifically, the report stated that "when we accompanied suppliers on their visits to beneficiaries' homes, we observed that routine maintenance for a concentrator consists of checking the filter to make sure it is clean and checking the oxygen concentration and flow rate with handheld instruments, tasks that can be performed in less than 5 minutes."

We found this information to be valuable in better understanding the cost of equipment, and the maintenance and servicing of oxygen concentrators. Accordingly, the information was an important consideration in developing the FY 2008 Budget proposal.

We took from the MedPAC recommendations on skilled nursing facilities to freeze payments. They looked at all the other things that I mentioned to Congressman Pomeroy in terms of indicators as to whether or not there should be payment changes, including access to capital, beneficiary access payments and costs, volume, quality, and the like.

So, that's in terms of where we are on the skilled nursing facility update. That's really where those proposals stem from.

In terms of oxygen equipment, there are a number of different pieces that I would like to address on that.

The first is new technology. We didn't actually propose to change the new technology payments until we know more about the new technology that's being provided, particularly with oxygen-generating portable equipment. We think it's too early for that, to make those recommendations.

Even though a beneficiary would own the equipment after 13 months, we would still have separate payments that we would make to suppliers for general maintenance and servicing every six months, delivery and refilling of both stationary and portable oxygen contents, reasonable and necessary repairs at any point in time in which they're needed, and replacement supplies and accessories.

So, even though a beneficiary would own the oxygen equipment, we would continue to pay for the servicing of that equipment.

Moreover, once the beneficiary passes away, the equipment would revert back to the supplier so the supplier has an additional incentive to ensure that that equipment is kept up to date.

The one thing that struck me in looking at this, and I haven't looked at the Office of the Inspector General report recently, so I can't address it recently, although I'm more than happy to get back to you and discuss it more specifically, the one thing that I recall is the percentage of beneficiary payments as a proportion of the stationary equipment that we provide, and if stationary equipment, whether it's a tank or a concentrator, costs between $600 and $800, what we have been seeing is that beneficiary co-payments often far exceeded that amount, and we didn't think that really made sense.

So, rather than just buy the equipment for that beneficiary, and then continue to provide services, maintenance, repairs, and the like, without regard to who owns the equipment over time, we thought was a more intelligent approach.

Then you talked about ambulance providers.

Ambulance providers we propose in 2008 get a 1.05 percent payment increase, and that's the consumer price index, which is how their update is normally done under current law, minus the pro-

ductivity of .65, which is half the productivity that the Bureau of Labor Statistics has come out with, at 1.3.

We're encouraging all providers to be more efficient by taking a half of the productivity off what their normal payment update would be, whether it's market basket or Cost Performance Index (CPI), and that's consistent with ambulance as it is with, say, hospitals and other payments that we are proposing.

Mr. ENGLISH. Thank you. I do have an additional question, but I think I'll do that in letter form, in recognition of the Chairman's request for brevity and the fact that I've already exhausted my time.

I thank you, Mr. Chairman.

Ms. NORWALK. Thank you.

Chairman STARK. Thank you, Mr. English.

We have allowed—if anybody has a chart they wanted to put up, we've let our IT people go home, so you're going to have to talk with your hands.

Mr. Kind.

Mr. KIND. Thank you, Mr. Chairman.

I want to thank Ms. Norwalk for your availability and testimony here today, and your patience, in light of the weather outside, but being from Wisconsin, we're not overly concerned about a little drizzle or freezing rain or what have you.

Let's get back to efficiency, just to follow up with Mr. English in that.

One of the concerns I had in the budget proposal by the Administration deals with the demonstration and evaluation projects that are out there, with the significant reduction in funding by over $28 million for the next fiscal year alone, and if we're really interested in trying to find the best practices and enhancing efficiency in the system, does that make sense, to be calling for huge cuts in these demonstration projects?

Ms. NORWALK. There are a number of different ways that we can fund a demonstration project, and typically, what happens with a demonstration is that most of it comes out of trust fund dollars.

It's the actual research and the writing of the report to ensure that the demonstration has been evaluated appropriately that comes out of our administrative budget.

These are certainly hard times for all of us in the Administration, and I think in looking at our overall budget, some of the priorities that we have include not just that, but also ensuring that we pay appropriately and that claims to all our providers are made on time, and so forth.

So, looking at the totality of our administrative budget, we thought that amount was appropriate, particularly given that we can work with others on the outside often to watch what they do in these——

Mr. KIND. Let me ask you this. I know a lot of my providers in western Wisconsin are moving forward and implementing efficient programs, like Six Sigma and Lean, things of that nature.

Should we be looking at ways to incentivize that type of behavior with our providers to encourage more providers to be looking at various programs like that——

Ms. NORWALK. Absolutely.

Mr. KIND [continuing]. To run a tighter ship?

Ms. NORWALK. Absolutely.

Mr. KIND. What recommendation would you have as far as proper incentives to get more providers to participate?

Ms. NORWALK. The way that Medicare runs generally is, SGR aside, if you look at our other payment programs, for example, if you look at the hospital payment system, because we based payments on DRGs, within a diagnostic-related group, there are a number of different types of procedures, and if you perform those procedures more efficiently, then you will be able to have a better return on your investment, and that's part of the issue when we're looking at margins across the board.

Those who are more efficient find that they have significantly higher margins than their counterparts who are inefficient.

Part of the productivity updates that the Bureau of Labor Statistics comes out with on an annual basis, and this year is projected to be 1.3 percent, MedPAC specifically said let's look at incentivizing efficiency by taking off half of that so that providers will be more efficient with their payment updates.

So that's why you see so much of the minus point market basket or CPI minis .65 in our program, and simply from a payment perspective.

One of the other places we've seen efficiency is in the premier demonstration for hospitals, and that's something that we're going to be expanding, at least allowing, or we hope to allow other hospitals outside of the premier chain to participate on a voluntary basis, and if they're more efficient and they provide both better quality care and have fewer readmissions, for example, then they get to keep——

Mr. KIND. Well, in another big area, and we're going to get there eventually, the question is how fast, and what the proper way is, is with health information technology.

Governor Doyle in Wisconsin just announced a major State initiative to try to get there quicker. Obviously, there are competitive advantages for doing so, too.

There again, in the area of incentivizing that behavior, are we going to have to eventually look at mandating the conversion to health IT (information technology), or do you think they're going to be able to do it on their own?

Ms. NORWALK. Well, I think we are not quite there yet. I think the first thing we need to be concerned about is interoperability and make sure that the systems can talk to each other——

Mr. KIND. Right.

Ms. NORWALK [continuing]. And if you mandate things too soon, I suspect that you end up spending more money than is productive.

What Medicare does is really focus on paying, we like to focus on paying for better outcomes.

In order to have better outcomes, I think providers are incentivized to purchase health IT systems. I don't think it makes sense for Medicare to pay for that. That program is really focusing on paying for health care services, but we should be looking at rewarding better efficiency and better outcomes, and that's a lot of

what our proposals do, and what we've been doing over time in terms of pay for performance.

Health IT is, without a doubt, a critical component of that, and that's why it's one of the Secretary's top initiatives.

Mr. KIND. Finally, I just want to echo the sentiments that Mr. Pomeroy just relayed in regards to rural representation and the concerns of rural providers and our patients there, too.

We have been operating under very a antiquated, unfair reimbursement system for some time. Many of us are obviously watching these Medicare Advantage plans very closely being set up in rural areas, that we don't fall into the same trap.

I'd like to follow up at some point with you about some of the concerns that I'm hearing developing out there in rural parts of the country, including my own and Wisconsin.

Ms. NORWALK. I look forward to talking to you about this.

Mr. KIND. Well, thank you again for your testimony.

Thank you, Mr. Chairman. Yield back.

Chairman STARK. Thank you, Mr. Kind.

Mr. Ramstad.

Mr. RAMSTAD. Thank you, Mr. Chairman.

Director Norwalk, as I'm sure you know, by any objective analysis, any national study, Minnesota has a history of delivering very efficient and very high-quality care.

Unfortunately, Minnesota's Medicare Advantage plans, however, are penalized for this quality care through inequitable payments.

According to the plans in my State, and this is corroborated by the Minnesota Senior Federation, what was reported by the Washington Post in late 2005 holds true today.

That is, despite higher quality care, over the average lifetime of a Medicare patient, CMS will pay about $50,000 more per Medicare beneficiary in Miami than in Minnesota—$50,000 more per patient in Miami over the lifetime of that patient than in Minnesota.

This means that there's about a $630 difference per month between the highest reimbursement and the lowest.

Please tell me, why hasn't CMS addressed this unfair, unconscionable, and unreasonable difference?

Ms. NORWALK. I think that one of the things that we have been focusing on is, in fact, paying for higher quality, and you can tell from reading any number of studies that more care does not mean necessarily better quality, and as we move to paying for performance and better—with our payment system, and becoming a smarter payer, I think that the Medicare Program will reward physicians and other providers in States like Minnesota where you see higher quality care, and take a second look in areas where that care may be both inefficient and not necessarily higher quality.

Many of our payment reforms over time, not just this year in this year's budget, but in past years, really have been focusing on paying for performance, and as we move there, and which we are doing at least from a pay for reporting perspective, we're taking the first baby steps to get there.

Those are the sorts of reforms I think that will reward the appropriate increases in quality that you're seeing in your State and that your beneficiaries are so fortunate to receive, as opposed to some

of the places, some of the quality care, and frankly, higher-cost care, we've been seeing in other parts of the country.

I agree with you that we need to be focusing, and being a smarter payer and focusing more on quality payments rather than just paying for a service because it's been provided.

[The information follows:]

> Since Medicare began making risk-based payments to private health plans in the mid-eighties, the Medicare law has spelled out the policies for setting the rates and CMS implements those policies. Those rates are now used in calculating benchmark amounts in the bidding system that was implemented starting in 2006. While differences still exist, changes in the BBA were specifically designed by Congress to address this concern and the differences are narrower than they were in 1997, when the BBA was enacted. At that time, the highest and lowest rates were $767 and $221, with a difference of about 250 percent. In 2007 the highest and lowest rates are $1279 and $692, with a difference of about 85 percent.
>
> Further, let me point out that if the proposal some are discussing to set MA rates at 100 percent of fee-for-service were to become law, the differences would certainly increase and funds available for extra benefits would be reduced. This would have negative effects on the thousands of MA enrollees in Minnesota and millions nationwide. Their existing benefits would almost certainly decrease and, if the experience several years ago is any indication, some plans would leave the program, resulting in significant disruption for affected beneficiaries.
>
> As I indicated previously, Congressional policies in the BBA had the intended effect of narrowing the disparities. This took place primarily through the floor rates, which were created in the BBA, and modified in subsequent changes to the Medicare law. In keeping with Congressional intent, the floor rates create MA payment rates in many counties that are higher than fee-for-service based rates, including in many counties in Minnesota. Let me reiterate that if MA rates were set at 100 percent of fee-for-service the disparities would increase, and there would be adverse effects on beneficiaries.

Mr. RAMSTAD. Well, as an advocate for going to a pay for performance model, if you will, system, I certainly hope that that provides a glimmer of hope and it's moving in the right direction.

Do you think in the meantime, should—why hasn't CMS ever advocated scrapping the unfair, unconscionable AAPCC formula and opting for a regional payment system, for example?

Ms. NORWALK. Well, we have done that in certain circumstances under the Medicare Advantage program, with regional PPOs, for example.

A lot of the payment changes to Medicare Advantage changed pretty significantly with the MMA, and now the payments really focus on the plan bids.

Now, I appreciate that the statutory amount of the benchmark is derived from fee-for-service payments, and I think as we change those fee-for-service payments, likewise in the Medicare Advantage program, you will see changes that will adjust as we pay more for quality and less simply for service.

Mr. RAMSTAD. Have you already seen a decrease in disparities between Medicare Advantage reimbursement rates?

Ms. NORWALK. I'll have to go back and check. I suspect there is still some disparity there.

The exact amounts, I haven't looked at recently. So, I'll have to go back and we can get back to you with an answer on how those changes are impacted across the country.

Mr. RAMSTAD. I appreciate that and I appreciate the fact you're mindful of this situation.

It's really hard to explain to Minnesota seniors how, really, they're cheated in the reimbursement system, if you will, vis-a-vis their counterparts in Florida, and so I just hope we can bring some reasonableness to the system and hasten it's arrival, because it couldn't come too soon for so many seniors back home.

Thank you.

Ms. NORWALK. We agree they pay for performance and paying better for quality is something that we need to do as soon as possible.

Mr. RAMSTAD. Thank you.

Chairman STARK. Would the gentleman yield for my suggestion?

Mr. RAMSTAD. Certainly.

Chairman STARK. If we could take that 600 a month that we're overpaying in Florida and buy round-trip tickets on Northwest Airlines for the people so they could fly to Minneapolis, we'd make you a hero. We'd bail out Northwest Airlines and——

Mr. RAMSTAD. I'll cosponsor the legislation, Mr. Chairman. Thank you.

Mr. EMANUEL. Mr. Chairman, you'll have to bring your shovel with you.

Chairman STARK. Mr. Emanuel.

Mr. EMANUEL. Ms. Norwalk, if I can turn to the SCHIP program, if that's okay.

Ms. NORWALK. Sure.

Mr. EMANUEL. By some estimates, there's about seven to eight million children—I would say it's a guesstimate—that are eligible for SCHIP and Medicare, but SCHIP principally, that are not enrolled.

Yet, in the President's budget, he proposes $5 billion over 5 years for SCHIP, in fact it has a, from present numbers, it has about a $223 million cut.

As having helped negotiate this when I was in the prior Administration, and this may be the son of a pediatrician speaking here, I'm a little—given that everybody knows that the problem here is that we have more kids that are eligible than are enrolled, and yet by estimates that we are going to need $15 billion, not the $5 billion requested, we're short already meeting our objective of what this program can do to cover children whose parents work full-time but don't have health care, and yet the President's budget rolls back the waivers that they have provided to States like Illinois to go above the 200 percent of poverty, doesn't provide the funding at the levels that are by any estimates, CRS being one of them, that says that you need 15, so it's way short, and third, has no real administrative programs to help enroll those kids who are eligible.

I think on every piece of the waterfront, the President's health care proposal as relates to children falls short.

Now, he says he wants to extend coverage to more and more Americans, but in the one program you have to be able to do it for children, which is the cheapest element of our health care system, kids, it doesn't meet any of the objectives, and by some estimates, this is in fact going to lead to a cut in kids receiving health care under SCHIP.

Can you explain to me what went on, having worked on budgets myself, in the mindset, given all the other choices you make in a $2.9 trillion budget, you could not find the resources to meet the basic objectives of a very successful program?

Ms. NORWALK. Well, we do think the SCHIP program has been very successful. It's very important to us, and we believe that covering kids is critical. So, that's——

Mr. EMANUEL. That part we agree on?

Ms. NORWALK. Absolutely.

Now, we certainly disagree with the premise.

First of all, $34 billion over 5 years we think is sufficient to cover all children who need health care insurance, and I can talk a little bit about the numbers and how we get to that number. In the——

Mr. EMANUEL. Are you saying—I don't mean to interrupt—are you saying that CRS and the others are wrong that your budget falls short in meeting the basic objectives of the SCHIP program?

Ms. NORWALK. We disagree on the numbers, and I can explain how we get to the numbers where we are.

First of all, in the past three years, enrollment in SCHIP has leveled off. We have 6.6 million children who were enrolled at some point in time in 2006 in SCHIP. We have over 29 million who were enrolled in Medicaid.

So, right there, you've got what, 36—we've got about 35 million people enrolled in either SCHIP or Medicaid last year.

Now, the total number, that's 45 percent of children across the country that are already enrolled in these programs.

So, I do not—we disagree and are more likely to look at, say, the Urban Institute study. We thought about 1.8 million children are left.

The way that our budget is set up is we have—we would—we think the $15 billion that the others are looking at include adults, and we have a different proposal for adults in the budget. As I'm sure you know, the affordable choices proposal, which I'm more than happy to discuss——

Mr. EMANUEL. Let me, since I'm only allowed 5 minutes, let me—could you take one more minute, though, on your presumptions going in, because there's something there that I don't quite either understand or I disagree with violently.

Ms. NORWALK. The total——

Mr. EMANUEL. You can have your choice, which one you'd like. Go ahead.

Ms. NORWALK. Thanks.

The total number of children in the country is 77.2 [sic] children, according to the Census Bureau.

Mr. EMANUEL. Million.

Ms. NORWALK. Those with private health insurance, not SCHIP or Medicaid, is nearly 51 million.

So, there are, what is that, 26 million or so that are left without private health insurance, at any income level, according to the Census Bureau.

If you look at the number who are in SCHIP at 66 million last year, or at 29.5 million in Medicaid, that's 35 million as opposed to 26 million.

Now, clearly, there's something different in terms of how those numbers are counted, but we——

Mr. EMANUEL. May I ask you this, then?

Ms. NORWALK. Sure.

Mr. EMANUEL. Are you saying that all the reports out there, regardless of non-political, that is, professional reports, that the notion that there are children eligible for SCHIP that are not enrolled, are wrong? That's number one presumption.

Two, that the resources that they say needed for the children, not for the adults, is woefully inadequate, you're saying that only 1 million children will go uncovered?

Ms. NORWALK. Well, currently, the number of children we see that meet the requirements—this is according to the Urban Institute—of the 13.3 million children, according to the Urban Institute, who appear eligible for SCHIP, nearly 4 million have SCHIP coverage—of course our numbers are a little bit different—6.6 million have employer-sponsored coverage, and nearly 2 million are uninsured.

I think that the Congressional Research, the CRS, Congressional Research Service, focuses on the program with no changes at all, and given that the program has a number of adults that are currently covered, and we have a separate proposal to cover those who are uninsured adults, frankly, at different income levels, or not at any income level, those who would need help because they have high health care costs without regard to their income level.

Our focus is really on the initial focus of the program, low-income children under 200 percent of the poverty level.

Mr. EMANUEL. Well, if I can, Mr. Chairman, just for one more minute?

Chairman STARK. Please.

Mr. EMANUEL. In short order, we'll be introducing legislation to accomplish things.

One, administrative efficiencies, whether it's presumptive eligibility, automatic enrollment, using other programs like food stamps and schools and school lunches, to enroll kids who are eligible, that all do it from an administrative standpoint, so I think there's a much larger number of children going without health care than you do from your presumption.

Second, a refundable tax credit for those above the 200 percent of poverty, to get there, and get up to a point like that. We'll be introducing legislation.

I think there is bipartisan agreement we need to make progress on health care in children. I think the President's budget is woefully inadequate in meeting the goals of covering all children, and we can get there given all the numbers that you said there and do it both through administrative efficiencies and a refundable tax credit.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Hulshof.

Mr. HULSHOF. Thank you, Mr. Chairman.

Let me return to an issue first addressed by my friend from Michigan, Mr. Camp, and that is the SGR.

Now, again, we speak in acronyms and probably most folks here in the room understand these acronyms, and for those at home who

aren't proud graduates of the George Mason University School of Law, we're talking simply about the way that doctors who see Medicare patients are paid, and it's the sustainable growth rate, and it's, I would say to my friend from North Dakota, Mr. Pomeroy, who amplified this point, this Subcommittee attempted in the last session of Congress to repeal this, in my view, flawed formula, and similar to what the Administration is discussing, moving to a performance type or quality initiative type of incentive, where we would not necessarily, Congress would not write the rules, for instance, for fields of specialty, but allowing the specialists themselves to choose the quality initiatives.

Having said that, though, the average physician payment for this calendar year of 2007 is roughly the same as it was in 2001, and yet physician practice costs have continued to increase.

Would you agree with me at least on that point, about physician practice costs going up, Ms. Norwalk?

Ms. NORWALK. I would—I suspect that's accurate.

Mr. HULSHOF. If—and again, amplifying the point made on health IT, health information technology, if physicians are not provided with annual updates to at least keep them current with their annual increase in costs, how can we expect them to invest in expensive health information technology systems?

So, my question, as I appreciate the desire of the Administration to work with us, we have suggested in the past removing physician administered drugs, and let me take your point as you've given it, that retroactively legally cannot be done.

You left open, or I didn't jot down your words quite well enough as far as prospectively.

So, here's the first question.

Is there a legal obstacle within the Administration removing physician administered drugs on a prospective basis?

Ms. NORWALK. Let me go back and ask my general counsel and get back to you before, since even though I went to law school, I'm not allowed to be a lawyer, I can only play one on TV, but I can't practice law in this position.

So, let me go back and ask them——

Mr. HULSHOF. Okay.

Ms. NORWALK [continuing]. And get back to you on that, because clearly that's an important point.

[The information follows:]

> Removing drugs from the SGR under existing authorities presents some tricky issues. The statute defines physicians' services for purposes of the SGR to include those other items and services specified by the Secretary that are commonly performed or furnished by a physician or in a physician's office. Prospective removal of drugs from the SGR would require a determination that the incident to drugs included in the SGR do not meet this criteria while other items such as clinical laboratory tests do.
>
> Prospective removal of drugs from the SGR is estimated to have no impact for the first 8 years of the 10 year period 2008–2017. In other words, removing drugs from the SGR on a prospective basis would not have any impact on the physician update until 2015. Removing drugs from the SGR on a prospective basis would, however, have the effect of increasing costs for taxpayers beginning in 2015 and the part B premium paid by beneficiaries beginning in 2015.

Mr. HULSHOF. Is there a policy rationale for not allowing—for removing, or refusing to remove physician administered drugs from the formula?

Ms. NORWALK. Well, the concern that—in fact, the statement that I made earlier about this topic was that even if we were to remove it prospectively, it barely dents the problem that we have on the SGR, and in fact, you really don't see any impact because of how the sustainable growth rate is calculated, you don't even see it have an impact for I think it's four or 5 years out.

It is something that when we sit down and work with MedPAC and the societies and with you and your colleagues, I think that it's something that we can discuss.

Mr. HULSHOF. Okay. Let me, in the remaining time, then, move to the 75 percent rule.

As we've talked about the physician formula, the SGR, there is the administrative side of it and then we can obviously legislate if we feel that administrative action is not taken sufficiently, and I will tell you that Mr. Tanner and I, my colleague from Tennessee and I, have introduced a bill, legislation on the 75 percent rule.

There—and you know this, Ms. Norwalk—there have been unbelievable advances in medical science that allow previously untreatable patients to receive rehabilitation services and have what we would term in a layman's term to be a full recovery.

Why hasn't the Administration made any serious attempt to modernize the 75 percent rule by at least expanding the diagnostic conditions that really haven't been defined for many, many, many years?

Ms. NORWALK. I'm trying to remember when it was. Maybe last year, the year before last, forgive me for not remembering the specific time, the 75 percent rule, you're correct, initially had not been changed for decades, and needed to be updated. It had 10 conditions that were incredibly outdated.

We did in fact go in and work with not only our own physicians within the CMS, but also within the entire Department, working with the National Institutes of Health and the like, to update those lists of conditions.

The 75 percent rule, of course, focuses on the most high acuity need patients in terms of their rehabilitation needs, and one of the things that we had been seeing over time is that these facilities were focusing more on simple knee and joint replacements that were less complicated, rather than focusing on the sort of care that you've just described, that might be available with newer technology, that can really help when there are co-morbidities and patients really need that higher acuity care.

So, we in fact did significantly change the different types of services that should be provided or that account for that 75 percent portion.

It's not that an Emergency Relief Fund can't provide care to other patients, only that we limit the payment, and we really want to focus those facilities for those higher-acuity needs.

Now, every year, we update and take a look at the conditions that would be covered within that 75 percent, and work with the medical societies to get the best information possible, so on an an-

nual basis, we'll be taking a look at those lists of conditions. As we have better information we would update that list.

Mr. HULSHOF. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Thompson.

Mr. THOMPSON. Thank you, Mr. Chairman.

Ms. Norwalk, I'd like to talk a little bit, or I'd like to hear from you a little bit on the issue of reimbursement rates and how they've been cut in this budget, and how that's going to impact problems that already exist, given provider shortages probably in any underserved area. My focus, given my district, is in rural areas.

Last week, Mr. Portman was here, and he said something along the lines of, well, with increased productivity, a lot of these problems can be solved.

I don't think I'm any different than anybody else in this Committee. I don't think any of us would want to go home and tell our doctors or our nurses that they just need to step up their productivity.

Being married to a nurse, I can tell you that if she were here, she wouldn't have been as calm as I was.

I represent some rural areas, one of which, Del Nort County, lost two surgeons and 10 primary care doctors in 2005 alone. They have one obstetrician. They have no psychiatrists and no cardiologists. I don't think that this cut in reimbursement rates is going to help them at all.

I'd like to get your take on how you see this particular portion of the budget impacting these rural communities.

Ms. NORWALK. You mention a number of different and very important topics.

The first, and you've talked about surgeons and obstetricians and so forth that you see leaving the area.

Of the things that we've been talking about today is the need to take a much closer look at the sustainable growth rate and how physicians are paid.

This is something that we will, I'm sure, have a lot more information——

Mr. THOMPSON. I'm less interested in what we should look at. I'm worried now, if your budget were to be enacted into law today, I'd have areas that wouldn't have any doctors, and the ones that were there certainly wouldn't be taking any Medicare patients.

Ms. NORWALK. Both MedPAC and our own research office has been focusing on the access to physicians across the country, and we do provide changes in payments for all different types of providers, whether they be physicians, and given where they live, and their wage index, for example, or whether it's other providers, and rural increases that we have seen historically to institutional type providers.

When we talk about productivity changes, and I'm sure I did not have the benefit of seeing Dr. Portman's testimony, but the productivity changes that we've been discussing earlier really focused more on the institutional provider types as opposed to the physicians, per se, in our budget.

I think that all providers need to be encouraged to provide the most efficient sort of care, particularly in an institutional setting, but would agree with you that we need to take a closer look at the physician piece.

Mr. THOMPSON. I've got some other issues I want to cover, so maybe if you could just let me know, and you could do it in a letter, what in your budget, what specifically in your budget demonstrates the Administration's commitment to addressing the provider shortages in rural areas.

I think you know how I feel on this. It's hard to increase productivity in any area of health care if you don't have any doctors.

Before my time gets away from me, I want to also align myself with Mr. Ramstad. You don't have to go to Michigan or Florida to see disparity in Medicare Advantage payments. You can just come to California and look at northern California versus southern California, and there's a stark difference.

This is something that needs to be fixed, and I would associate with anybody, line up with anybody to help do that.

Your budget, in brief, includes a legislative proposal to clarify rehabilitative services, and your revenue tables show that the proposal would cut approximately $2.3 billion from Medicaid over the next 5 years.

The details that I saw are somewhat vague, and so I'm interested in knowing what specific changes you're looking at. and I am particularly interested in adult day health care services, and I'd like to know if these proposals will impact California and the seven other States that provide these services as an optional benefit under their Medicaid State plans.

Ms. NORWALK. The general concern we have about rehabilitative services in the Medicaid program is that it hasn't been particularly well defined, and so States are using a number of different pieces that would—that may not be the most appropriate for Medicaid reimbursement.

In terms of adult day care services, I'll have to go back and ask my staff more specifically, but the general premise is to ensure that we are providing what's appropriate, we're paying for services that are appropriately paid for under the Medicaid program, that aren't paid for already under other programs, and merely they're asking the Federal Government to supplant other payments. So, we——

[The information follows:]

The President's FY 2008 Budget includes a regulatory proposal to ensure the fiscal integrity of claimed Medicaid expenditures by clarifying the service definition and providing that Medicaid rehabilitative services must be coordinated with but do not include services furnished by other programs that are focused on social or educational development goals and available as part of other services or programs. These services and programs include, but are not limited to, foster care, child welfare, education, child care, prevocational and vocational services, housing, parole and probation, juvenile justice, public guardianship, and any other non-Medicaid services from Federal, State, or local programs. The proposed regulation would provide guidance to ensure that services claimed under the optional Medicaid rehabilitative services benefit are in fact rehabilitative outpatient services, are furnished by qualified providers, are provided to Medicaid eligible individuals according to a goal-oriented rehabilitation plan, and are not for services that are included in programs with a focus other than that of Medicaid.

States have provided coverage for adult day health care (ADHC) services through one of two ways: waivers for home and community-based services

(HCBS) or under the authority of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89, P.L. 101–239). section 6411 of OBRA 89 permitted California and seven other States providing ADHC services as a Medicaid State plan option to continue this coverage until the issuance of final regulations on rehabilitative services that clarified the elements of ADHC services that could be offered under the Medicaid rehabilitative services benefit. Beginning January 1, 2007, ADHC became coverable as a service in the new HCBS State plan option under section 1915(i) of the Social Security Act, as amended by section 6086 of the Deficit Reduction Act of 2005. As we develop the proposed rule, we will consider whether to continue coverage of ADHC services under the optional rehabilitative services benefit in light of the new State plan option available under section 1915(i).

Mr. THOMPSON. Well, can I find out how it's going to impact these States that do this?

I know in California, I don't know if it meets your definition, but I know that it's working, it's keeping people out of skilled nursing facilities, it's saving money, it's keeping people at home, it's keeping communities together.

Ms. NORWALK. We do think that home and community-based services are critically important for the points that you just mentioned, and that keeping people out of the nursing home is a goal that certainly we all share, and I would anticipate that those sorts of services would be able to continue.

Now, the regulation is something that we're currently developing, so——

Mr. THOMPSON. If your regulation takes away this flexibility that these folks have—you're going to be hurting the very people that you claim that you're helping.

Ms. NORWALK. Well, we certainly agree with you on the premise that providing services in the home and in the community is something that is critically important, rather than——

Mr. THOMPSON. Well, I'd rather your budget tracked with that, rather than you agreeing with me.

Ms. NORWALK. Well, we'll work with you as the regulation is—once the regulation is published.

Chairman STARK. Mr. Becerra.

Mr. BECERRA. Thank you, Mr. Chairman.

Ms. Norwalk, thanks for your patience, and hopefully, we'll get you out before the weather turns completely ugly.

Ms. NORWALK. That's all right, I can walk home.

Mr. BECERRA. I'll join you.

A couple questions, and I know I'm going to run out of time, so I'll just try to go at them pretty quickly.

In your budget, you have a cut in moneys for research demonstration programs, which to me seems like a wrong way to go.

You go from about 62 million in last year's budget to about 28 million that you've allotted—I'm sorry—34 million that you've allotted in this year's budget for research demonstration and evaluation projects, which in many cases provide us with the innovation and those new ideas that sometimes we need to try to do things smarter and in a less expensive way.

Give me a sense of why we should support something like that cut.

Ms. NORWALK. I think it's very difficult times for all of us. We are all looking under enhanced budget pressures.

From a budget perspective, there are a lot of priorities that CMS needs to meet within our administrative budget, first and foremost of those, ensuring that we pay providers correctly and appropriately, and so forth.

In taking a look at the overall budget and making sure that we can make the most of what we do have, we think that $34 million is sufficient to continue the research projects that we have ongoing, particularly the most critical ones, as well as looking and working with outside partners as we have over time to make sure that if there are things that we aren't doing that those projects, or something that they are looking at somewhere across the country, whether they be partners, educational institutions, and so forth.

We also have partners within HHS that do a fair amount of research that we can use, whether it's our assistant secretary for planning and evaluation, and the like.

So, it's an area where we thought that we might be able to have economies elsewhere.

Mr. BECERRA. I think I'd like to explore that with you a bit more——

Ms. NORWALK. Sure.

Mr. BECERRA [continuing]. Because while you can probably find some savings to cut virtually half of the budget, I think probably, either we had a lot of fat in the budget to begin with, and a lot of bad research was being done, or a lot of good research is going to pay the price of these cuts.

You mentioned provider cuts and how we have to focus on priorities.

Provider cuts, it seems to me that there's no resolution in the President's budget when it comes to how we deal with providers who are seeing some pretty significant cuts in their reimbursement rates, and many of these providers—doctors, hospitals—are very concerned that, at the rate that we're going, that they may have to drop out of the Medicare system altogether because they can't afford the reduced reimbursement rates that they're receiving.

This is something that we've obviously tried to resolve on a longer term basis, and I know you've talked a bit about this, so I won't way more than to ask if you can please make sure that, as we move forward, that we have the help of the Administration to come up with a solution that's not just bipartisan, but has the support of the executive branch, as well, because I think it's a terrible way to budget when every year we talk about a piecemeal approach to this issue.

Every year, providers are coming, wondering, not knowing. There's no predictability. There's no stability in how they can try to budget for themselves, long-term, about the patient loads they can take, what type of expansion they can afford to undertake.

I think we have to give the health care system and our providers more stability and predictability in how we're going to go about making sure Medicare is their for folks in for those who provide it.

Ms. NORWALK. I agree.

Mr. BECERRA. One other area: In California, with the waiver that we have, we are having some real issues and I know there are some concerns. There is a proposal that actually we spoke about over the phone—some issues that we spoke over the phone about

not too long ago, CMS Rule 2258–P, it would change the way you categorize some of the entities that are eligible for reimbursement, public entities. You would also narrow this set of costs that can be reimbursed. Those are all things that while they seem to be providing on paper a savings of $3.5 to $4 billion over 5 years would probably take the hide out of many of our public hospitals and many of our private hospitals that are safety net hospitals.

I know they are in panic mode trying to figure out how, especially in California where we have such a large population of uninsured, that they are going to manage with these cuts that are going to principally fall on public institutions or private hospitals that are safety net facilities. So, I am wondering if you can give us—I know that you mentioned or CMS has mentioned on many occasions verbally that the State will not be effected by this rule and these cuts, and I am wondering if you can tell us now for the record that indeed this rule and the changes it would impose would not affect the State of California in harmful cuts?

Ms. NORWALK. Well, we have been very concerned in looking at the Certified Public Expenditures rule that you mentioned. What we propose is that we pay—that we only pay governmental unit providers, providers that are actually units of Government, 100 percent of costs. Let me say that again, so we are paying them 100 percent of costs.

Mr. BECERRA. So, with the University of California hospitals, they qualify as one of those public institutions?

Ms. NORWALK. As a part of our rule, we have actually gone to the State and asked them to fill out a form so that they can get back to us information as to who is the governmental unit provider and who is not. So, I do not know from a specific basis whether or not they qualify under that.

Mr. BECERRA. You have proven my point, that is the dilemma they face, they are not sure if they are going to get cut, and the UC system has some of the best hospitals around, public facilities, that stand to lose because they have no certainty as to whether or not they are going to face the cut or not. It is extremely exasperating.

Ms. NORWALK. One of the things that we have found actually is that providers, rather than getting to keep these payments, this is really about an intergovernmental transfer issue, what we have been seeing with States across the country, and that we have been cleaning up over time as State plan amendments come into us, States have been saying, "Okay, here we will pay this Government provider 110 percent of cost." Then what happens is they take back 30 percent of that after the Federal Government has matched it and that money goes into recycling. What we would rather see is we would rather see the governmental provider get 100 percent of cost. The other thing our rule does is say you cannot submit that money back to the State for a recycling purpose. So, what this is really intended to do is two things: One, make sure that governmental providers get to keep the payments; and, second, make sure that there is not a recycling scheme that runs afoul with provider tax and donation requirements. So, that is really the element of what is here. Now, we will work with you when we get more back from the States as to who qualifies as what providers.

Mr. BECERRA. My time has expired so I want to end here but say I thank you for your response. I know you are trying to work this through, and I hope that you will stay in touch with us because I think it is clear from my question and your answer that this is very complex and confusing and the worst thing we can do is end up with providers and beneficiaries and patients who ultimately suffer as a result of the confusion that we caused with these rules and so forth. So, I thank you for your response. Mr. Chairman, I yield back my time.

Ms. NORWALK. Thank you.

Chairman STARK. We are happy to welcome Mr. Crowley to the Committee and without objection, he will be recognized to inquire.

Mr. CROWLEY. Thank you, Mr. Chairman, thank you for your accommodations, both yourself and the Ranking Member for allowing me the opportunity to ask a question of the administrator. Ms. Norwalk, thank you for being here today. The Fiscal Year 2008 budget includes severe cuts to Medicare and Medicaid, one such cut is the in-patient hospital market basket update, which many hospitals require to keep up with the cost of inflation. MedPAC recommended to Congress that they give the full market basket update to in-patient hospitals. However, this Administration chose to cut it by .65 percent this year and every year thereafter for I believe the next 5 years. How are hospitals supposed to continue to provide high-quality care when they are not able to keep up with the cost of inflation?

Ms. NORWALK. There are a number of different points that I would make, first of all that the update that we are proposing in our budget for hospitals is a 3.25-percent increase in payments. Historically, the Medicare Program over the past 10 years has paid about 63 percent of the market basket. This particular increase would be 83 percent of the market basket. So, if you look at the historical nature of hospital payments over time for the Medicare Program, we are actually considerably on the higher side over the past in fact even 20 years. I have been spending a fair amount of time recently poring over the MedPAC testimony and the MedPAC recommendations, and I think there are a number of things that are important. What their initial recommendation was in March of this past year was in fact market basket minus half the productivity rate, and they were still debating this in fact last month, a few weeks ago, in the discussion. When they talk about having just a market basket increase, they did it in context with some other proposals that we also did not get a chance to pick up in this particular budget, things that relate more to pay for performance, but they did not entirely dismiss the idea of the importance of productivity and having some productivity adjustments in payment systems in order to make this program more sustainable over the long term. MedPAC is critically important, they do fantastic work. We pay very close attention to their own research, but we do research on our own, both through the capital markets folks that we have who work at CMS as well as through our Office of the Actuary and looking at varying other market projects. What we have seen is that many hospitals are in fact very efficient and could absorb this and those who are in very competitive markets, who have had difficulty or haven't had private payment pressures, are the ones who

are perhaps less efficient and those who would be most disadvantaged by this particular proposal, but we would like to reward efficient behavior, particularly of our hospital providers. I can assure you we do pay very close attention to what MedPAC puts out and their recommendations, and I think their January testimony is very instructive on this point.

Mr. CROWLEY. Well, coupled with the fact the President has a scheme that he is proposing to Congress to help the uninsured by providing to an estimated three to five million individuals in this country opportunities for insurance within the private market, three to five million people out of a total of roughly 47 million uninsured in this country, my concern is—of which 2.7 million are in New York State—my concern here is that in cutting these hospitals, which is the safety net for the uninsured in this country, and particularly in city like mine of New York City where those that we know that are uninsured as well as those who are not documented in this country use emergency room for their care, that cuts to those hospitals will have a severe impact in their ability to deliver for the uninsured. So, it is really a great example of robbing Peter to pay Paul, giving opportunity maybe if it were to go through to three to five million people, yet leaving 42 to 45 million people with even less resources to deal with their own health issues. I just want to relay that to you that that is why I am concerned about these cuts or what you may argue as an increase but not enough as far as I am concerned and therefore is a cut as far as I am concerned in my hospitals.

Ms. NORWALK. The Affordable Choices proposal focuses two different components, the tax component, which is a $3 to $5 million increase, but the HHS component of Affordable Choices we anticipate that there will be actually significantly more individuals covered. For example, there is a State that has come into us with a proposal that pretty much meets the President's proposal around Affordable Choices, and they anticipate covering $1.1 million in that particular State alone. One of the things that the Secretary has been doing the past number of weeks, and will continue to do, is meet with Governors across the country to get a better sense of what it is that they would like to do to help cover the uninsured in their State. I have no doubt that a visit—in fact, I think he was in New York—is going to New York in the next couple of days so I have no doubt that that is going to be a topic on the agenda, to make sure that we can take into account the plans that Governor Spitzer has for New York.

Our focus is rather than paying indirectly for care, or frankly the care that is provided in hospital emergency departments, any emergency department physician will tell you is an unfunded mandate. It is not something that Medicare and Medicaid directly pays for. Instead of doing that, we thought it made a lot more sense to help subsidize health insurance, not just from a tax proposal perspective where you would make the tax proposal fairer for those who don't have access to employer-sponsored insurance but provide through the HHS proposal subsidies much like you see for example in the SCHIP program that we talked about earlier today, subsidies for employer-sponsored insurance if it is available and if it is not, subsidies to buy insurance in a more robust non-group market. So,

these two things together we anticipate will cover significantly more than $3 to $5 million that people have been focusing on from a tax perspective and that we will have better information as we learn more from Governors and State legislatures about what they are looking to do in their State on the HHS side of the Affordable Choices proposal, but I totally appreciate that at some point, the hospitals will continue to see these patients who do not have insurance. So, clearly, there needs to be some safety net that remains in place no matter what happens, and we will come back and look forward to working Congress more specifically when we have learned more from the States as the Secretary goes out and talks to governors and State legislatures.

Mr. CROWLEY. Thank you. I know my time has expired but to be a poor person and relying upon Government to make sure the safety net is there, I do not think there is a full faith and confidence in the poor that it will be there, but I thank you for your time. Thank you, Mr. Chairman.

Chairman STARK. It is good to have you. Would any Members like to add one additional brief question that they may not have had a chance to ask previously?

Mr. THOMPSON. Thank you, Mr. Chairman. Ms. Norwalk, I would like to talk to you about an issue that I am concerned about, the MMA, Index to part B Premiums to Income. Basically, those who make higher than $80,000 pay a higher premium. In your budget proposal you expand the premium indexing to Part D. However, you eliminate the current requirement to annually index the income thresholds to inflation. I am a little concerned about that because it sounds to me like we have got an alternative minimum tax (AMT) problem down the road, and I am wondering if that is something that you guys have talked about? Do you have any idea how eliminating the inflation index will impact beneficiaries over time if it does come to fruition?

Ms. NORWALK. We did take a look at the 10 year projections as to how many beneficiaries would be impacted under Medicare part B. Under current law, it would be 6.3 percent of beneficiaries, which equates to nearly 3.3 million, would pay an additional or higher premium. Under the proposed law, it is 9.6 percent and that equates to five million.

Mr. THOMPSON. To it is 3 percent more when?

Ms. NORWALK. 2017, 10 years from now. So, it is an additional $1.7 million in 2017.

Mr. THOMPSON. It goes up from there?

Ms. NORWALK. I would presume that there would be additional beneficiaries who are impacted every year, yes.

Mr. THOMPSON. So, you are going to double the number of folks who are having to pay so does that mean it creeps down?

Ms. NORWALK. I am not sure I understand the question but you would move from 3.2 million under current law to five million under proposed law, so an additional 1.7 million 10 years from now would pay an additional part B premium.

Mr. THOMPSON. Thank you.

Chairman STARK. Mr. Camp?

Mr. CAMP. Mr. Chairman, I just wanted to ask if we had some discussion about SCHIP and the funding for SCHIP, whether it

was adequate. I just want to clarify that I do believe the President's budget calls for a $5 billion increase in SCHIP funding over 5 years, does it not?

Ms. NORWALK. Correct, so it is $5 billion per year that is currently in the budget. It is almost $4.8 billion additional money and then $4 billion that would be reallocated, that is how you get to the $34 billion.

Mr. CAMP. All right. Thank you very much.

Ms. NORWALK. Thank you.

Chairman STARK. I just wanted to close with a couple of comments. I am concerned, and perhaps you could just drop us a note on this, that the elimination of the bad debt provision is going to impact very disproportionately on low income. It hits rural clinics, it hits inner city clinics. There is already, it seems to me, enough inclination by providers to duck the indigent where they can. To pick up the copays, as I believe the bad debts have in the past, as I say, I am concerned with it mostly hitingt people who can least afford it. Now, it may be abused. It may be just a way to duck the copays in advance, and to the extent that it is abused, I would not object, but to the extent that it is just fishing around for some savings, it is something that I would want you to re-think.

Now, the other thing that I would want you to re-think, it is only because I want to see all those people sitting behind you smile, is I am not real happy with your administrative budget. It is a little known fact that at least in the period when I used to chair this Committee, we religiously went to the appropriations Committee to ask for more funding for HHS and their administrative budget. It is the largest bureaucracy in our Government and to me one of the most important. I know that you are doing your best to try and save money, but maybe we would start to get information more quickly if in fact the administrative budget were increased. If you do not object strenuously,——

Ms. NORWALK. We have our friends from the Office of Management and Budget watching.

Chairman STARK [continuing]. I think that it is something that I might ask the Ranking Member to look at with me and see whether we might not whisper in the appropriations Committee's ear that we think that we would all be better served if at least we kept up with inflation. Those are just comments, and I want to thank you very much. I hope you get home before we are all snowed in. I thank your staff very much for staying and bearing with us in this. We will look forward to working with you in the months ahead.

Ms. NORWALK. Indeed, thank you.

[Whereupon, at 3:45 p.m., the hearing was adjourned.]

[Questions submitted by the Members to the witness follow:]

Question Submitted by Chairman Stark to Ms. Norwalk

Question: I'm concerned that the elimination of the bad debt provision is going to impact very disproportionately on low-income. It hits rural clinics, it hits inner city clinics. There is already enough inclination by providers to duck the indigent where they can. And to pick up the copays, as I believe the bad debts have in the past, I'm concerned with mostly hit people who can least afford it. I also know it may be abused. It may be just a way to duck the copays in advance, and to the extent that it is abused, I would

not object. But, to the extent that it is just fishing around for some savings, it is something that I would want us to re-think.

Answer: The bad debt policy, adopted in 1966, allowed Medicare to cover the unpaid deductible and coinsurance amounts that arose in connection with the provision of covered services to Medicare beneficiaries. The policy was meant to avoid the cross-subsidization that might occur if hospitals or other entities tried to recoup Medicare bad debt from other payers. Currently, Medicare is the only payer that reimburses bad debt for services paid on a reasonable cost basis or under a prospective payment system.

Bad debts are obligations between providers and beneficiaries. Now that providers are reimbursed through prospective payment systems or fee schedules, we do not believe it is Medicare's responsibility to cover out-of-pocket costs that beneficiaries do not pay. The President's fiscal year (FY) 2008 Budget proposes to eliminate bad debt reimbursement for all providers over a 4-year period.

As the stewards of the Medicare Trust Funds, it is important that we encourage providers to be proactive in pursuing the bad debts owed to them. This proposal will create greater incentives for providers to recoup their debts, leading to greater program efficiency and strengthening the long-term financial security of the Medicare Program.

We do not believe that this provision will cause providers to suffer financially because bad debt is only a small fraction of Medicare revenues for providers. For example, the reduction in Medicare bad debt payments accounts for less than 1.0 percent of revenues for hospitals, only 0.5 percent of Medicare revenues for skilled nursing facilities, and 0.1 percent for dialysis facilities.

Question Submitted by Mr. Thompson to Ms. Norwalk

Question: Can you explain to me what specifically in the budget demonstrates our commitment to addressing the provider shortages in rural areas?

Answer: The Centers for Medicare & Medicaid Services (CMS) is committed to the needs of all people with Medicare, especially those residing in rural communities. In addition to taking steps to secure the long-term sustainability of the Medicare and Medicaid programs, the President's fiscal year (FY) 2008 Budget demonstrates the Administration's commitment to preserving and expanding health insurance coverage for all Americans. While there are no provisions specifically addressing provider shortages in rural areas in the budget, CMS does have programs in place that aid access and improve quality in designated rural health areas.

CMS has taken a number of administrative steps over the past few years to better address the concerns of rural providers. CMS conducts regularly scheduled conference calls known as the "Rural Health Open Door Forum" to provide a venue for rural providers to inquire about policies, upcoming changes, and share payment concerns. The Department also established a Department-wide Rural Health Task Force to increase responsiveness to rural concerns.

In addition, CMS has made several important regulatory reforms that assist rural providers. For example,

- In the FY 2007 hospital inpatient prospective payment system IPPS final rule, CMS adopted cost weights over a 3-year transition period. Cost weights generally increase payments to rural hospitals because of the redistribution between medical and surgical diagnosis-related groups (DRGs) that occurs due to the cost-based weights. Rural hospitals tend to have heavy concentrations of medical DRGs and therefore are expected to experience increases in payments.
- In the long-term care hospital (LTCH) final rule for rate year (RY) 2008, CMS extended the "25 percent rule." In general, one way the 25 percent rule was expanded was to provide a payment adjustment to an LTCH that has more than a certain percentage of its Medicare discharges admitted from any individual referring hospital that is not co-located with the LTCH. Even under the expanded policy, patients who achieved high cost outlier status at the referring hospital before being discharged to the LTCH are not counted toward the applicable threshold for that referring hospital. Therefore, the payment adjustment would be applied for those Medicare discharges in excess of the applicable threshold that had not reached high cost outlier status at the referring hospital before being discharged to the LTCH. Generally, CMS provides a higher threshold for rural hospitals in recognition of the unique needs of these hospitals.

- In the physician fee schedule proposed rule for 2008, CMS is proposing to add neurobehavioral status exams to the list of Medicare telehealth services. The neurobehavioral status exam is furnished by a physician or psychologist and includes an initial assessment and evaluation of mental status for a psychiatric patient.
- CMS has made $195 million in grants available to Gulf Coast States impacted by Hurricane Katrina. These grants will serve to strengthen access to health care services in the Gulf Coast region and to relieve economic pressure suffered by health care providers in the region.

As you know, recent legislation signed into law by the President has included several provisions to enhance beneficiary access to quality health care services and improve provider payment in rural areas. For example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) included a number of provisions to improve rural health care. These provisions include the creation of a new Physician Scarcity Area bonus payment program along with an updated Health Professional Shortage Area bonus payment program, which reward both primary and specialist care physicians for furnishing services in the areas that have the fewest physicians available to serve beneficiaries; the development of a graduated adjustment/add-on payment for low-volume hospitals; the redistribution of unused resident positions, with hospitals located in rural areas receiving top priority for such positions; and significant improvements to the Critical Access Hospital program, including increased payments to 101 percent of reasonable costs and flexibility to use up to 25 beds for acute care.

CMS has also been directed to conduct a number of demonstrations focused on the delivery of care in rural areas. For example, section 409 of the MMA established a demonstration to test the delivery of hospice care in rural areas; section 410A of the MMA established a 5-year demonstration for up to 15 hospitals test the feasibility of establishing Rural Community Hospitals; and section 434 of the MMA authorized a new demonstration project under which Frontier Extended Stay Clinics in isolated rural areas are treated as providers of items and services under the Medicare Program.

Finally, the Tax Relief and Health Care Act of 2006 (TRHCA) included a number of provisions that foster rural health programs in many ways. In particular, TRHCA extended the floor on Medicare work geographic adjustments by 1 year (now set to expire January 1, 2008 instead of January 1, 2007); extended reasonable cost payments for certain diagnostic laboratory tests furnished to hospital patients in certain rural areas by 1 year; and extended the hospital wage index reclassifications authorized under section 508 of the MMA through the end of FY 2007. CMS has worked expeditiously to implement all of these provisions, recognizing their importance to rural communities.

Questions Submitted by Mr. Camp to Ms. Norwalk

Question: As you know, with the passage of the Omnibus Budget Reconciliation Act in 1990, pharmaceutical manufacturers were required to pay rebates to the States to help reduce the price of prescription drugs. These rebates are related to the costs in State Medicaid programs and some specific State-mandated programs. From my understanding the total amount of rebates paid each year varies, but is between $4 and $8 billion.

Each fiscal quarter, pharmaceutical manufacturers receive invoices which list the amount of rebate to be paid. However, I'm told that CMS does not require that the information provided by States to the manufacturers be done in any standard form and without data to back up the request. Is this true? Does CMS have the authority to require States to supply consistent and accessible rebate data? If not, what authority would you need to establish such a system wide standard?

Answer: Section 1927(b)(2)(A) of the Social Security Act (the Act) requires States to provide information to manufacturers "in a form consistent with a standard reporting format established by the Secretary." The standard format established by CMS is the OMB-approved form, CMS–R–144. States may implement this requirement in various formats, so long as the thirteen data fields included on the CMS–R–144 are present for each drug. The CMS–R–144, also referred to as the State Rebate Invoice (invoice), is used for the current rebate quarter, as well as for adjustments to previous quarters. Further, the national rebate agreement provides manu-

facturers with an avenue to dispute the data provided on the invoice, and request additional documentation from states.

Question: I have been working with Members of this Committee and the Department to address the difficulties surrounding intravenous immune globulin therapy (IVIG) treatments. As you know, due to past reimbursement difficulties, patients with immune deficiencies were forced to visit the hospital to get their treatment, instead of at their physician's office.

I am pleased that CMS has preliminarily addressed this issue by providing add-on payments to physicians for the administration of IVIG. I also understand that the Assistant Secretary of Planning and Evaluation (ASPE) and the Office of Inspector General (OIG) are conducting studies on patient access to IVIG and the IVIG marketplace, respectively. Would you please provide the Committee with an expected release date of these studies?

Answer: We expect the study funded by the Assistant Secretary of Planning and Evaluation in the Department of Health and Human Services (HHS) to be released shortly. We expect the study conducted by the HHS Office of Inspector General to be available in the next few months.

Question: Included in the President's 2008 Budget is a $1 billion savings for 2008 and $10.235 billion over the 5 year period for "Improved Medicare Efficiency, Productivity, and Program Integrity." I agree that increasing Program Integrity is often a good investment. Would you please explain how you CMS calculates these savings? Does some portion of the remaining dollars reflect additional reductions in payments to providers? More specifically, how do you expect to you measure Medicare "efficiency" and Medicare "productivity"?

Answer: The President's fiscal year (FY) 2008 Budget indicates that administrative actions will be taken to encourage program efficiency and strengthen the long-term financial security of the Medicare Program. The President's Budget estimates cost savings of $1 billion in 2008 and $10 billion over 5 years. The $10 billion in Medicare administrative savings can be achieved through a series of administrative actions that weed out inappropriate payments and maximize efficiencies in our provider payment systems. Areas where payment policies can be improved include: enhancing program integrity efforts and examining provider payments, including payments for acute care hospitals, home health agencies, inpatient psychiatric facilities, long-term care hospitals, and hospices. Specific policies will be proposed via the normal rulemaking cycles.

Question: As you know, current law permits coverage of oncology drugs used off-label if they are supported by statutorily recognized compendia. Of the three recognized compendia, two are no longer functioning, leaving Medicare carriers with limited access to sanctioned information in determining coverage decisions for anti-cancer therapies.

In March of 2006, nearly a year ago, the Medicare Coverage and Advisory Committee met and recommended a revised compendia list. In December, Chairman Bill Thomas asked HHS to act as soon as possible to update the list of three compendia and to report by to Congress by the end of January on this matter. Can you report to us that you have been able to review this and are prepared to update the list?

Answer: We believe that it is appropriate to create a process, incorporating public notice and comment, to receive and make determinations regarding requests for changes to the list of compendia used to determine medically-accepted indications for drugs and biologicals used in anti-cancer treatment as described in section 1861(t)(2)(B)(ii)(I) of the Act. The FY 2008 proposed rule to update the Physician Fee Schedule proposes such a process.

[Submissions for the Record follow:]

Statement of American Association for Homecare

Mr. Chairman, on behalf of the American Association for Homecare's more than 3,000 member locations serving Medicare beneficiaries in every state in the nation,

we sincerely appreciate the opportunity to submit testimony before the Committee on Ways and Means Subcommittee on Health reviewing the President's Fiscal Year 2008 Budget with Acting CMS Administrator Norwalk.

The American Association for Homecare (AAHomecare) represents all lines of service and therapy in the homecare community, including home medical equipment providers, respiratory therapy, infusion therapy, telemedicine, and rehab and assistive technology.

AAHomecare is deeply concerned about and strongly opposes several provisions of the Administration's proposed 2008 budget that would weaken access to homecare for millions of older and disabled Americans.

The Administration's proposal would heap new cuts on the nation's homecare sector by requiring reductions to payments for homecare equipment, therapies, and visits from home health agencies. The proposed budget includes particularly severe cuts to home oxygen therapy. These homecare reductions come on top of numerous other cuts and annual payment update freezes implemented in recent years.

Homecare provides a clear path to more cost-effective care in Medicare and Medicaid. Homecare delivers value for every healthcare dollar, is clinically effective and preferred by patients and families. These proposed cuts serve only to hobble the health care infrastructure that our nation desperately needs.

Cuts to Home Oxygen Therapy

AAHomecare opposes the proposal in the Administration's budget that would force Medicare patients to assume the burden of owning and managing medical oxygen equipment in their homes after only 13 months of rental.

On February 5, the Association issued a statement objecting to the 13-month provision along with the National Home Oxygen Patients Association and the National Association for Medical Direction of Respiratory Care, a physicians' group. The statement said, "We believe the proposed change in payment methodology places an unfair, unsafe, and unrealistic burden on the beneficiary." The organizations are concerned that Medicare policy is increasingly at odds with the clinical needs of home oxygen therapy patients, as well as physicians' and home oxygen providers' ability to deliver optimal home respiratory care. (See full statement at www.aahomecare.org and attached.)

The typical Medicare home oxygen beneficiary is a woman in her seventies who suffers from late-stage Chronic Obstructive Pulmonary Disease (COPD) with associated severe low levels of oxygen in her blood (hypoxemia). Approximately 15 million Americans have been diagnosed with COPD, and an estimated 12 to 15 million more remain undiagnosed. Medical oxygen is a highly regulated prescription drug. Because of services required for providing oxygen therapy, it is best suited to a continuing, uninterrupted relationship with a qualified home oxygen provider. Prior to the Deficit Reduction Act of 2005 (DRA), the home oxygen benefit in Medicare provided for rental as long as the prescribed oxygen therapy was medically required by the patient. Home oxygen has been the target of budget cuts for many years: Medicare reimbursement for oxygen therapy has been cut by nearly 50 percent over the past decade.

Access to Power Mobility for Disabled Americans

The Association also opposes a provision in the Administration's budget that would "establish a 13 month rental period for power wheelchairs." The Association believes that this change would reduce beneficiary access and increase costs to the Medicare program. Currently, Medicare permits a beneficiary to choose to purchase a power wheelchair when it is prescribed by a physician. When the beneficiary chooses to purchase a power mobility device, Medicare payment is made on a lump sum-basis.

In October 2005, the Senate debated a provision to eliminate the first-month purchase option for power wheelchairs and decided to reject this policy change from the budget reconciliation package. The amendment was defeated based on the following reasons:

- Beneficiaries in need of power mobility devices suffer from long-term debilitating conditions that are not short-term in nature.
- Many power wheelchairs are custom-configured and individualized for the patient. These are not commodity items.
- Eliminating the first-month purchase option would severely curtail beneficiary access as the supplier will be unable to cover the significant up-front service costs that go into the provision of the most appropriate power mobility device to accommodate the beneficiary's needs.
- More than 95 percent of all power wheelchairs are purchased in the first month because beneficiaries who meet the coverage criteria have long-term life needs.

Payment Freeze Hurts Home Health Agencies

The Association opposes the proposed five-year freeze (from 2008 to 2012) to the Medicare market basket payment update for home health agencies and the proposed market basket reduction of .65 percent for each year thereafter. While healthcare inflation has increased annually at more than 6 percent, home health agencies have sustained a number of reimbursement cuts in recent years that have hurt their ability to integrate new technologies, hire and retain staff, and initiate advanced clinical protocols.

Medicare home health providers are currently participating in a one-year collaboration with the Centers for Medicare and Medicaid Services to reduce the rate of hospitalization for Medicare patients. A reimbursement cut will reduce resources required to invest in telehealth and other health information technology to achieve transformational change in the quality of care and avoid unnecessary institutional costs for the Medicare program. In addition, the dramatic rise in fuel costs over the last two years has had a particularly negative impact on home health providers, whose nurses, therapists, and aides often have to drive great distances to provide health care services to patients in their homes.

Secretary Michael Leavitt has called for greater use of home- and community-based care in Medicaid because "it's not only where people want to be served, but it's radically more efficient."

The Association believes that the same principle should be applied to Medicare as well. Homecare, the most cost-effective, clinically-effective, and consumer-preferred modality of care, constitutes only about 5 percent of the Medicare budget (1.8 percent for durable medical equipment and 3.6 percent for home health agencies), yet constitutes nearly 20 percent of the Administration's recommended cuts.

AAHomecare appreciates the opportunity to present these comments for the record and for your consideration of the critical issues that confront the homecare community and the patients we serve.

Supporting Quality Health Care Services at Home

News Release

Contacts: Michael Reinemer, 703–535–1881 or 703–535–1881 (cell);
michaelr@aahomecare.org

Walt Gorski, 703–535–1894 or 703–407–4865 (cell);
waltg@aahomecare.org

Patients, Physicians, and Providers Oppose Cuts to Medicare Home Oxygen Therapy in President's Proposed 2008 Budget

ALEXANDRIA, VA, February 5, 2007—Today, a group of organizations representing home oxygen therapy patients, physicians, home oxygen providers, and oxygen system manufacturers issued a statement opposing provisions in the President's proposed 2008 budget that would threaten the home oxygen therapy benefit in Medicare.

The group, which includes the American Association for Homecare, the National Association for Medical Direction of Respiratory Care, and National Home Oxygen Patients Association, strongly objects to a proposal in the 2008 budget that would force Medicare patients to assume the burden of owning and managing medical oxygen equipment in their homes after only 13 months of use.

The statement says, "We believe the proposed change in payment methodology places an unfair, unsafe, and unrealistic burden on the beneficiary." The entire statement can be viewed at www.aahomecare.org.

The organizations are focused on chronic obstructive pulmonary disease (COPD) patients and their safe and effective respiratory management in the home. The group is deeply concerned that Medicare policy is increasingly at odds with the clinical needs of home oxygen therapy patients, as well as physicians' and home oxygen providers' ability to deliver optimal home respiratory care.

The typical Medicare home oxygen beneficiary is a woman in her seventies who suffers from late-stage COPD with associated severe low levels of oxygen in her blood (hypoxemia). COPD is the leading cause of morbidity and mortality worldwide and is the only leading cause of death for which both prevalence and mortality are rising. COPD is a chronic, debilitating disease characterized by severe airflow limitation resulting from chronic inflammation of the airways, decrease in functional lung tissue, and the dysfunction of pulmonary blood vessels.

"The President's proposed budget significantly impacts citizens least able to manage ownership of respiratory medical equipment," said Jon Tiger, president of the

National Home Oxygen Patients Association. "It leaves them without a network to ensure proper functioning of the equipment and to whom concerns can be raised. The proposal also removes the incentive for manufacturers to continually improve their equipment and will result in used prescription equipment ending up in the secondary market."

Tyler Wilson, president and CEO of the American Association for Homecare, stated, "The proposed change to home oxygen therapy policy will hamper patients' access to the therapy and discourage investment in new oxygen technology. We oppose forcing ownership on the patient, which saddles the beneficiary with unnecessary burdens. Moreover, home oxygen has been the target of budget cuts for many years. Congress has reduced Medicare reimbursement for oxygen therapy by nearly 50 percent over the past 10 years."

Approximately 15 million Americans have been diagnosed with COPD, and an estimated 12 to 15 million more remain undiagnosed. COPD costs the U.S. economy more than $18 billion per year in direct medical costs and an estimated $11 billion in indirect costs.

Medical oxygen is a highly regulated prescription drug. Both medical oxygen and the systems that deliver oxygen require a prescription from a physician. Because of services required for providing oxygen therapy, it is best suited to a continuing, uninterrupted relationship with a qualified home oxygen provider. Prior to the Deficit Reduction Act of 2005 (DRA), the home oxygen benefit in Medicare provided for rental as long as the prescribed oxygen therapy was medically required by the patient.

The patient, physician, and provider organizations endorse the new national COPD public education campaign launched by the National Heart, Lung, and Blood Institute, which is designed to encourage better diagnosis, treatment, and awareness about COPD in order to spare patients the suffering and costs of this disease. (Visit the campaign website at www.LearnAboutCOPD.org.)

The American Association for Homecare (AAHomecare) represents all lines of service and therapy in the homecare community, including home medical equipment providers, respiratory therapy, infusion therapy, telemedicine, and rehab and assistive technology. AAHomecare represents more than 3,000 member locations in all 50 states.

Statement of Heart Rhythm Society

The Heart Rhythm Society (HRS) thanks you and the Ways and Means, Subcommittee on Health for your continued hard work and leadership in recognizing the importance of establishing a sustainable Medicare physician reimbursement system, so that the current flawed SGR payment formula will not hinder health care providers from providing high-quality care to the nation's Medicare beneficiaries. We appreciate the opportunity to submit testimony regarding the President's Fiscal Year 2008 budget proposal.

HRS is the international leader in science, education and advocacy for cardiac arrhythmia professionals and patients, and the primary information resource on heart rhythm disorders. We are the preeminent professional group, representing more than 4200 specialists in cardiac pacing and electrophysiology. HRS serves as an advocate for millions of American citizens from all 50 states, since arrhythmias are the leading cause of heart-disease related deaths. Other, less lethal forms of arrhythmias are even more prevalent and account for 14% of all hospitalizations of Medicare beneficiaries.[1]

The Heart Rhythm Society wishes to express deep disappointment with the President's FY 2008 Budget, since it does not address the broken Medicare physician payment system, which will cut physician payments by 10 percent next year and does not provide payments in line with rising practice costs. The numbers speak for themselves. Over the next eight years, Medicare payments to physicians will be slashed nearly 40 percent.[2] Practice costs will increase about 20 percent over that same period.[3] Without adequate funding, physicians cannot make needed investments in health information technology and quality improvement efforts to ensure patient access to high quality health care. Decreased funding for Medicare payments to physicians would detrimentally affect Americans' ability to receive critical cardiac treatment.

Only physicians are subjected to the flawed Sustainable Growth Rate (SGR) formula, not other health care providers, such as hospitals or skilled nursing facilities. The SGR formula creates negative updates tied to the fluctuations of the Gross Domestic Product (GDP). These fluctuations, however, have very little correlation to

the actual cost of providing patient care. Additionally, the SGR does not take into account the increased number of Medicare beneficiaries, as well as expanded coverage of services and evolving medical technology that improves the quality of care. Physicians should receive positive updates that reflect practice cost increases, like the 2006 rates increases for home health providers (+2.5%), hospitals (+3.7%), Medicare Advantage plans (+4.8%) or nursing homes (+3.1%)[4]

In order to preserve Medicare patients' access to quality heart rhythm care, HRS strongly urges Congress to include provisions in the FY 2008 budget to permanently replace the SGR with a system of payment updates, reflecting increased practice costs. If you have any questions or would like additional information, please contact Amy Melnick, Vice President, Health Policy. Thank you again for the opportunity to submit testimony.