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ENHANCING MEDICARE FOR THE 21ST CENTURY: A PRESCRIPTION BENEFIT FOR SENIORS

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BEFORE THE

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ENHANCING MEDICARE FOR THE 21ST CENTURY: A PRESCRIPTION BENEFIT FOR SENIORS

WEDNESDAY, AUGUST 27, 2003

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
St Louis, MO

The committee met, pursuant to notice, at 10 a.m., in Little Theater, Harris-Stowe State College, 3026 Laclade Avenue, St. Louis, MO, Hon. James M. Talent presiding.

Present: Senator Talent.

Mr. GIVENS. Good morning. I am Henry Givens, Jr. I am President of Harris-Stowe State College and we are honored to have all of you with us this morning. The Honorable Senator James Talent, distinguished panelist, city and state legislators, community leaders, members of the Harris-Stowe State College family, distinguished guests, ladies and gentlemen, welcome to Harris-Stowe State College and a special welcome to this historic event.

Harris-Stowe is greatly honored and privileged to have been chosen as a site for this Congressional hearing relating to healthcare benefits. The information that you will receive today, is one of the utmost importance to a significant portion of the population in metropolitan St. Louis and in the Nation at large.

We are all deeply indebted to our U.S. Senator from Missouri who has brought these distinguished panelists to our community. As you know, Senator Jim Talent campaigned for the U.S. Senate on a platform of healthcare, job economic growth and national defense. Missourians elected him to serve our great State in the U.S. Senate last November.

Senator Talent served for 8 years in the U.S. House of Representatives and 8 years in the Missouri House. Now, as a freshman U.S. Senator, he holds important Senate leadership positions and is working diligently to be Missouri's healthcare advocate.

Let me just mention a few of the important bills that he has already sponsored in the U.S. Senate. The Small Business Fairness Act to provide healthcare to small business owners and workers.

Another key legislation is the Sickle Cell Treatment Act to expand treatment and services for patients with this disease. This legislation has been rightfully called the most significant sickle cell disease legislation to be introduced in 20 years.

Senator Talent has a long record of public service to the citizens of Missouri and now to the American people all across the nation. It is, therefore, my distinct privilege and great honor to introduce

the convener of this highly important congressional hearing, the Honorable James M. Talent, Senator from the great State of Missouri. Senator Talent.

OPENING STATEMENT OF SENATOR JAMES M. TALENT

Senator TALENT. Thank you, Henry. That was more than I deserve and better than I often get, so I appreciate that very much. It is a great pleasure to be here at Harris-Stowe. When I visited last, Dr. Givens said, you need to come by and see our new Emerson Center. I said, well, not only am I going to come by and see it, we may use it for something that we are doing in town, and he was very generous and offered, and we took him up on it. It certainly is a magnificent facility, a part of a magnificent institution.

I could spend the whole hearing talking about Harris-Stowe, but suffice it to say that, under Henry Givens leadership, this institution has continued to play a vital role in the African-American community, but more broadly speaking, in the St. Louis community as well.

We were just talking about the partnerships in which Harris-Stowe is at the center. I know that that role is going to grow, and I have been pleased to help in any way I can. We are grateful, again, to the college and to Dr. Givens for allowing us to be here.

I am going to convene now, a hearing of the U.S. Senate Special Committee on Aging. It is a committee that I wanted to be on and was pleased to be appointed to when I went into the Senate, because of the importance of the issues that this committee confronts, one of which, of course, is prescription drugs, but also the future of Medicare in general, how to strengthen it, and how to strengthen Social Security.

These issues are our key not only to the tens of millions of seniors today, but to all of us, because all of us are hoping, if we are not already senior citizens, to someday become senior citizens. We are all going to have to confront these issues.

Today we are going to discuss improvements to the Medicare program that I hope and believe are going to provide Missouri seniors and the disabled with access to quality, affordable healthcare, including prescription drug coverage.

Whoever is chairing the hearing gives a brief opening statement and then introduces the first panel, and I am going to do that, and then asks some questions of the panel.

Typically, we do not have questions directly from the audience in a Senate hearing. I chafe at that. But what we've done is ask you to fill out question cards and I have one here.

Medicare consists of two distinct parts, Part A, which is a hospital coverage, and Part B, which is the supplementary medical insurance, which is technically voluntary but which almost everybody participates in.

Medicare has been that way since it was introduced in 1965, and I like to refer to Medicare as a tremendously important program that's done good for millions and millions of people, including both of my parents. But it is a program that was devised in 1965 and has not, structurally, really changed since.

Now in 1965, if you think about it, really nobody who had health insurance coverage had prescription drug coverage. It was a pretty

small part of people's treatments. I have asked physicians about this—we have physicians here today. In those days, you got prescription drugs if you had any problems with infections, usually on a short term, or for pain. It just was not a regular course of disease management or treatment. In fact, disease management really wasn't known that much then.

So Medicare reflects those times. It was fine when it was introduced, but now, just about everybody who has health insurance coverage has prescription drug coverage, and most people who have coverage have access to options that will help them with things like wellness and disease management.

About 16 percent of the Missouri population is enrolled in the Medicare program. This is a vital issue for Missouri seniors, and today's hearing is going to focus on the legislation which Congress is currently working on and how it can help seniors and the disabled have access to quality, affordable prescription drug coverage.

Now the good news: Legislation has recently passed the Senate and the House to provide for prescription drug coverage in a context where we are going to strengthen access to Medicare for everybody. We have an historic opportunity. This is something people have been talking about for a long time. The window is now open, and I am hopeful that we are going to get this bill through this window in the next couple of months.

We are going to hear testimony from several panels of witnesses on several related issues. The Senate passed bill provides benefits to seniors including new prescription drug coverage as well as a voluntary option that offers seniors the kind of choices that other people who are insured currently enjoy.

I am going to introduce the panelists at the end of my remarks. Let me say also a comment about this hearing and the context of it. I did a number of town hall meetings earlier in the year on prescription drugs and heard from seniors about what they wanted in a prescription drug plan. It was all common sense. It was exactly what you would expect.

They wanted coverage that would apply to everybody, be voluntary, as immediate as possible, have reasonable co-pays and deductibles, and not force them or their doctors to prescribe only certain kinds of prescription drugs.

The bills that have passed the House and Senate, I am pleased to say, are consistent with all those principles. They're very different, but each of them respects those important principles.

I am hopeful that the conference committee between the House and Senate will produce a final bill in the next couple of months. When it does, we will have another series of meetings around Missouri to explain what is in the bill so that people know the details of it.

We don't have those details available, but I wanted to have a hearing to touch base on the underlying principle. I wanted to get an authoritative official from Washington who could discuss these issues and be available to answer questions, and that's really why we are here today.

Under both the House and Senate bills, seniors will pay an estimated $35 a month premium, about a dollar a day, for prescription drug coverage delivered through a Medicare—approved healthcare

plan. The deductibles in the House and Senate bill vary from $250 to $300 a year.

Both bills provide additional help for lower income seniors and people who have very high prescription drug costs. So folks in those situations will save more, although everybody will save.

Both bills provide for immediate implementation of a Medicare drug discount card that will save people from 10 or 15 to 25 percent. We can do that right away. The rest of the plan will take several years to set up, so there is some immediate relief, which is something that is important to me. The President has asked Congress to provide seniors with that card starting in 2004.

Low-income seniors will also immediately receive—or receive within the six months after the President signs the legislation, which is as close as Washington gets to immediate, a $600 to $800 subsidy in each of the next 2 years while the full plan is implemented.

In addition to the prescription drug benefit, the Medicare package would allow seniors to choose from a variety of Medicare-approved health care plans to fit their individual health needs. The idea here is to try and create a system for seniors which is similar, if they choose, to the Federal Employee Health Benefit Plan, which has worked very well for Federal employees.

These plans will offer seniors more benefits, such as better preventative care for diseases like cancer, heart disease and obesity. Care coordination, which is like disease management for conditions such as diabetes, heart disease and Alzheimer's Disease, protection against high out-of-pocket costs, and greater choice of the doctors and hospitals they want for treatment.

Everything about the new Medicare plan is voluntary, and that is important—and that's both in the House and Senate bills—and that will be in the conference report as well.

Both bills include provisions that seniors have told me are important and I agree reasonable deductibles, strong catastrophic protection, provisions to help low income seniors and voluntary options.

Senator TALENT. Today's hearing is divided into two panels. I will briefly introduce the panelist, they will testify, and then I'll ask some questions, including questions that have been submitted to me from the audience.

The first panel features Claude Allen, is the Deputy Secretary of Health and Human Services at the U.S. Department of Health and Human Services in Washington. He flew into town this morning just to participate in the hearing. I am pleased that he was able and willing to do that.

Our second panel features Missourians who will testify about their hands on experiences with the Medicare program. The first witness on the second panel is Audrey Vallely a senior citizen. I had a chance to meet Audrey before, and she's going to tell us about her experiences on Medicare.

I expect that she will be a very effective witness, and we are looking forward to hearing your story, Audrey. I want to thank you for being here, and also congratulate you on the birth of your first great-granddaughter. You must have married very, very young to have a great-granddaughter.

The second witness on the second panel is Dr. Frederick DeFeo, the President of the Missouri State Medical Association, which represents 5,000 doctors.

Our third and final witness on the second panel is Ron Levy, who's wearing two hats for us today. He's the Regional President and System Vice President of SSM Health Care. He's going to speak on behalf of that organization, as well as on behalf of the Missouri Hospital Association.

I want to thank all of the witnesses for being here and everybody in the audience for coming. I also want to say that I will be available after the hearing, along with my staff, to visit with the folks here. If you have additional questions about prescription drugs or any other issue, if you don't have a chance to speak with me today, I invite you to call my office here, which is 432–5211.

Thank you all. We will go right to the first panel. Usually the first panelist is somebody working in the Administration, and we have a very high-ranking official from the Department of Health and Human Services, Claude Allen.

Deputy Secretary Allen is the No. 2 man at the Department. He's at the Federal Government's principal agency for protecting the health of all Americans and providing essential human services.

The Department includes some 300 programs covering a wide spectrum of activities. As Deputy Secretary, Mr. Allen works closely with Secretary Tommy Thompson on all major policy and management issues, and he serves as the Department's Chief Operating Officer.

He's going to describe the President's plan to strengthen and modernize Medicare, and he'll focus on the prescription drug and voluntary health plan components.

Thank you, Secretary Allen. I appreciate your interrupting a vacation to come in, so I am very grateful. Please proceed with your testimony.

STATEMENT OF CLAUDE ALLEN, DEPUTY SECRETARY DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. ALLEN. Thank you, Senator. Thank you very much. Senator Talent, I want to thank you and Chairman Larry Craig for inviting me to Harris-Stowe State College here in St. Louis to discuss Medicare reform, and in particular, the value of a prescription drug benefit in the Medicare program.

I have submitted written testimony for the record and I will summarize here in my oral statement.

Senator TALENT. Yes, please do.

Mr. ALLEN. Thank you. President Bush and Secretary Thompson are strong believers in Medicare and know the tremendous benefit it has been to our country. Medicare is nearly 40 years old, however, and is out of date with modern medicine. That is why the President has urged Congress to provide more choices and benefits to Medicare beneficiaries.

Senator Talent, I want to thank you for your leadership on this important issue and for helping pass Senate Bill 1. Through your hard work and the work of your colleagues in Congress, we truly are in the midst of making the most sweeping changes to Medicare since the program began in 1965.

To bring about real change in Medicare, we need to combine the strength of the current program with the best of the current private sector and health insurance market, the Federal Government's experience in running the largest employer sponsored health insurance program and Medicare's experience in running a program for 40 million seniors and Americans with disabilities.

As successful as this program has been, it has not kept pace with decades of dramatic improvements in healthcare. As a result, Medicare beneficiaries today lack many of the options and benefits, such as prescription drug coverage, available to millions of other Americans.

If we were creating the Medicare program today, we would model if after what consumers are receiving in today's healthcare marketplace, more choices and better benefits. All seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare, as well as better coverage for preventative care and serious illnesses.

Beneficiaries should have the option of keeping the traditional plan with no changes, but we must offer more choices for better health plan options like those available to all Federal employees and their families.

Medicare legislation should strengthen the program's long term financial security with better management, streamlined regulations and administrative procedures and stronger fraud and abuse enforcement. Most importantly, Medicare should encourage high quality healthcare for seniors.

The President's framework in both bills in Congress, gives seniors the choice of options and under all of the options seniors get more benefits, including prescription drug assistance.

I want to just go over those options with you briefly. In the first option, seniors can stay and from additional Medicare and get the fee for service system they enjoy currently with more benefits including prescription drug coverage.

In the second option, seniors can choose enhanced Medicare and get prescription drug coverage, full coverage for disease prevention, including screenings for cancer, diabetes, and osteoporosis, and protection from high out of pocket costs associated with lengthy hospital stays or lengthy care.

Then last, under the third option, seniors can choose what we are calling Medicare Advantage. Medicare Advantage will give the benefits of low cost, high coverage managed care plans, which many seniors prefer and receive currently, and a subsidized prescription drug benefit.

All comprehensive Medicare drug benefit proposals will require significant lead time prior to implementation. But we know that seniors need help right now. That is why the President's framework and Congress both have designed to provide significant and immediate assistance to low income beneficiaries with their prescription drug costs.

To ensure that seniors are provided help with their prescription drug costs as soon as possible, they will be provided with a drug discount card that is estimated to achieve discounts of 10 to 25 percent on the costs of prescriptions by pooling the buying power of Medicare participants and other cost saving measures. In addition

to the discount card, the President's framework would provide low income seniors with a $600 annual subsidy for drug coverage.

One of the priority areas that I deal with on a daily basis at the Department, is the elimination of health disparities that we see in healthcare among communities of color. Statistic after statistic shows that communities of color fare worse than White Americans among diseases such as cancer, diabetes, cardiovascular disease, HIV/AIDS and conditions such as obesity and hypertension.

The Medicare options that I described will increase the options for healthcare services for minorities. By providing better benefits and more choices, African Americans, Native Americans, Hispanic/Latino and Asian American/Pacific Islander seniors will have better options for obtaining healthcare.

By providing assistance for health insurance, increasing sources of primary care, such as through the president's community health center initiative, and working with communities of color to break down the stereotypes and distrust of the healthcare profession, we can end health disparities in this country.

I would be remiss if I did not mention the great work of historically Black colleges and universities, like Harris-Stowe State College, perform every day to help end health disparities.

Senator Talent, seniors and people with disabilities in America need access to a prescription drug benefit. They need modern benefit options in Medicare. This is the year to get it done and we look forward to working closely in a bi-partisan manner with the conference committee to get a good bill on the president's desk as soon as possible.

Again, I want to thank you for inviting me here today and look forward to answering any questions that you may have or the audience informs will be presented.

[The prepared statement of Mr. Allen follows:]

TESTIMONY OF

CLAUDE ALLEN
DEPUTY SECRETARY
DEPARTMENT OF HEALTH & HUMAN SERVICES

ON
ENHANCING MEDICARE FOR THE 21ST CENTURY:
A PRESCRIPTION BENEFIT FOR SENIORS

BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING
AUGUST 27, 2003

Chairman Craig, Senator Talent, distinguished Subcommittee members, thank you for inviting me to Harris-Stowe State College, here in St. Louis to discuss the need for and the value of a prescription drug benefit in the Medicare program. President Bush and Secretary Thompson believe Medicare is the binding commitment of our society to our most vulnerable citizens and that this commitment to the American people should be kept. To this end, the President has urged Congress to provide more choices and better benefits to Medicare beneficiaries bringing Medicare into the 21st Century. In strengthening and improving a program what is now a $241 billion program, we need to combine what we know are the strengths of the Medicare program with the best of the current private health insurance market and the Federal government's experience in running the largest employer-sponsored health insurance program. As successful as the Medicare program has been, it has not kept pace with decades of dramatic improvements in health care. As a result, Medicare beneficiaries today lack many of the options and benefits, including prescription drug coverage available to millions of other Americans.

IN NEED OF MORE CHOICES AND BETTER BENEFITS

When it was created in 1965, Medicare was modeled after the Blue Cross and Blue Shield coverage existing at that time when health insurance did not offer preventive care or catastrophic protection and usually did not include a prescription drug benefit. Times and Blue Cross plans have changed, but Medicare has not changed with them. Not only must Medicare include the benefits we have all come to expect, but we should also give Medicare beneficiaries the same options that Americans under age 65 enjoy. If we were creating the Medicare program today, we would model it after what consumers are receiving in today's health care marketplace: more choices and better benefits.

Seniors and people with disabilities, particularly those who are low-income, need prescription drug coverage now – it is long overdue -- and it is a major priority for President Bush and Secretary Thompson. But we must also update the program's structure to make the best use of today's modern health care delivery methods to maximize the benefits for current and future participants while addressing the long-term sustainability of the program. All Americans should be able to choose a health care plan that meets their needs at affordable prices. When people have good choices, and people are given different options, health plans must compete for business. That translates to higher quality and better coverage.

PRESIDENT'S FRAMEWORK

The President proposed Medicare reform efforts in July 2001, when he released his framework for Medicare modernization. Modernized Medicare includes an improved traditional fee-for-service plan and improved health insurance plan options. On March 3, 2003 the White House released the 21st Century Medicare: More Choices-Better Benefits; A Framework To Modernize And Improve Medicare where the President committed up to $400 billion over the next ten years as part of his 2004 Budget to modernize and improve Medicare. In the Framework the President says:

1. All seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare.
2. Modernized Medicare should provide better coverage for preventive care and serious illness.
3. Beneficiaries should have the option of keeping the traditional plan with no changes.
4. Medicare should provide better health insurance options, like those available to all federal employees.
5. Medicare legislation should strengthen the program's long-term financial security.
6. The management of the government Medicare plan should be strengthened so that it can provide better care for seniors.
7. Medicare's regulations and administrative procedures should be updated and streamlined, while the instances of fraud and abuse should be reduced.
8. Medicare should encourage high-quality health care for seniors.

The opportunity to make these changes to strengthen and improve Medicare is now. Since the President released his Framework, Congress has continued to work to develop meaningful, comprehensive Medicare reform, particularly prescription drug coverage. Mr. Chairman, Senator Talent, I would like to take this opportunity to commend you for your leadership on the important issue of Medicare modernization. Through your work and the work of your colleagues in Congress, we are on the brink of making the most sweeping changes since the programs began in 1965.

While Congress has yet to finalize all the details, passage of Medicare reform legislation could result in significant alterations to the Medicare program as we know it, including preventive health services, various regulatory reforms, a drug card with subsidies for low-income seniors, more choices for all seniors, and perhaps the biggest and most widely discussed provision, a prescription drug benefit and. The Administration is pleased to see that the legislation pending in Congress has incorporated many of these important reforms as outlined in the President's framework.

The Administration looks forward to working with Congress on this important legislation.

MORE CHOICES -- INCLUDING TRADITIONAL MEDICARE

Since these are such sweeping changes, I would like to provide some detail about these provisions. We believe Medicare beneficiaries should be given more choices in how they receive their health care and these choices should be strictly voluntary. For example, those beneficiaries with retiree benefits from their former employer should be able to keep their current benefits. Those seniors who are happy with their current coverage in traditional Medicare should be able to keep that coverage. **Traditional Medicare will continue to be there for those seniors who want it.** But all seniors should be offered a range of options from which to choose, both government-run Medicare and private-sector plans. And all of these choices -- all of them -- must include access to prescription drug coverage.

Improvements to Medicare should not force changes on today's Medicare beneficiaries, who are satisfied with the current system. But those who want more choices should be able to choose these options. Medicare beneficiaries should have the chance to select the health plan that fits their needs best -- people want the same options at 65 years of age that they want and have at 64. Under the President's proposal, beginning in 2006, Medicare beneficiaries will be given the choice of three options: Traditional Fee-For-Service Medicare, New Enhanced Fee-For-Service Medicare and Medicare Advantage. The Administration is pleased to see these options are included in both the House and Senate bills.

ADDRESSING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE

Another issue that is always on our minds when we discuss enhancing Medicare for the 21st century is eliminating racial and ethnic disparities in health care. Recently, the President said, "...medical care costs too much and many have no health coverage at

all… we must work toward a system in which all Americans have a good insurance policy, choose their own doctors, and in which seniors and low-income Americans receive the help they need." The Department of Health and Human Services and the Centers for Medicare & Medicaid Services are committed to eliminating racial and ethnic disparities in health care services.

HHS pays for health-care services for 70 million beneficiaries through the programs that it administers -- Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). Although HHS spends one out of every three dollars in the healthcare system nationally, it does more than just pay health care bills. HHS works hard to ensure that every American who is eligible for services from these programs actually enrolls and receives the care they deserve.

We are working to eliminate disparities caused by people unable to receive health care. The three priorities, as stated in the Healthy People 2010 project supported by HHS are, providing health insurance, providing an ongoing source of primary care, and reducing barriers to care. Those barriers may be the lack of insurance coverage, nearby facilities, health care professionals, or cultural or language differences.

Addressing Language Barriers

In Medicare alone, we estimate that 12 million of our nearly 40 million beneficiaries may not be able to access the health care services they need as a result of cultural and language barriers. As our non-English speaking populations continue to increase, we recognize the need to provide Medicare health information to our beneficiaries in languages other than English and in the languages of the beneficiaries. To more effectively reach the underserved Hispanic/Latino populations we translated the *Medicare & You* handbook and the *Guide to Health Insurance* into Spanish.

We are committed to the national goal of eliminating longstanding disparities by the year 2010 and continue the progress the nation has already made in improving the

overall health of the American people. CMS in particular, continues to make significant progress in many areas affecting African Americans, Hispanic Americans, Asian Americans, Pacific Islanders, Native Americans, and Alaska Natives. We are providing greater access to preventive health services through outreach and education, research, and data collection.

African American Population

To strengthen our ability to meet the needs of aging African Americans, we are reaching out to African Americans in rural areas of Mississippi and South Carolina with information about health services and disease prevention. To support this initiative, we are partnering with Harris-Stowe State College as well as other Historically Black Colleges and Universities (HBCU), and State agencies to disseminate publications (about Medicare, Medicaid, and SCHIP) that include State specific information.

We are currently partnering with an HBCU to develop and conduct a pilot project that will address "Diabetes in the African American Community." Through this project we will be able to evaluate the effectiveness of diabetes management intervention strategies and provide information about diabetes in the African American community.

Hispanic American Population

As a result of our commitment to address health disparity issues among the Hispanic American community, we are partnering with a Hispanic Serving Institution to develop a pilot community participatory intervention project for type 2 diabetes. This intervention project will measure the participants' attitudes, knowledge, and behaviors associated with diabetes prevention, treatment, and control.

Native American/Alaska Native Population

We have been working with the Indian Health Service for a number of years to make sure that Medicare and Medicaid payments to Indian Health Service facilities reflect the full cost of providing services. This cost report methodology, together with better

efforts to enroll eligible Indian people and legislative changes expanding the scope of covered services has led to an increase in health insurance reimbursement of 146 percent since fiscal year 1995. We are completing a study of enrollment trends and barriers to enrollment in fifteen states so we can better target our outreach and enrollment efforts.

We sponsored a conference on long term care for Tribal leaders last year and now we are partnering with Salish-Kootenai (Koot 'nee) Tribal College (SKC) to develop a Long-Term Care Toolbox that will provide Tribal leaders with information to assist them in identifying and meeting the long-term care needs of their communities.

CONCLUSION

Seniors and people with disabilities in America need a drug benefit, and they need modern benefit options in Medicare. America needs a 21st century Medicare plan that provides better coverage, including access to prescription drugs -- and is free of racial and ethnic disparities in health care. This is the year to get it done. The Medicare reforms currently under consideration in the Congress are revolutionary undertakings, and are highly complex. We look forward to working closely and in a bipartisan manner with the conference committee to get a good bill on the President's desk as soon as possible.

Additionally, as you heard here today, we have a variety of efforts and research projects underway at CMS and the Department to eliminate racial and ethnic disparities in health care. This is a priority for me and I know that it is a commitment for Secretary Thompson and the Administration. I hope that I have been able to express the Administration's dedication to strengthening Medicare, and to eliminating racial disparities, as well as our commitment to work with you to do so. I look forward to answering your questions.

Senator TALENT. Thank you, Mr. Deputy Secretary. Now I am going to ask you some questions that I have heard from seniors around Missouri and others. Of course, this subject is something that those of us who have elderly parents—and my Dad died last October and my Mom died about 15 years ago—are as or even more interested in understanding than they are——

Mr. ALLEN. Absolutely.

Senator TALENT [continuing]. Because sometimes folks aren't as interested in their own health as their kids may be.

Mr. ALLEN. That's right.

Senator TALENT. There's many children of folks on Medicare who are worrying about their mom and dad getting their prescription drugs. So everybody is concerned about it and they raised these issues with me. Let me just raise some of them with you——

Mr. ALLEN. Certainly.

Senator TALENT [continuing]. Since you are the expert on this. Assuming we get this bill passed this year, let's start with the drug discount card, how soon will that be available?

Mr. ALLEN. As we said, we would like to have it available as soon as possible, and so what we are predicting is, as soon as the legislation's signed, the drug discount card—the 10 to 25 percent discount that seniors and those on Medicare would be entitled to—would be available within 6 months after the date of passage. So we are anticipating that will be 6 months after signing of the legislation.

Senator TALENT. Now I hope that we will expedite that as much as possible, No. 1, and No. 2, that the procedures for getting the card will be as clear as possible and we'll make it available to seniors as soon as possible.

Mr. ALLEN. That's exactly right. At the centers for Medicare/Medicaid services, we have already begun working in this area. As we have had some experience already with drug discount cards, we believe we can get it up and operational in that amount of time. Six months is the outside window that we are shooting for. We would try to get it sooner, if possible.

Senator TALENT. You understand the skepticism of Missourians who have dealt with big bureaucracies before and, I mean, 6 months is an outside target for me. Since we are fairly certain that this is going to happen, I hope the Department is planning now and will be able to swing into gear.

Mr. ALLEN. That's exactly right. We are already planning for that. It is a high priority for both the President and Secretary Thompson because we know that, of all the benefits, while we are looking at Medicare needing major reforms, are they going to take a period of time?

The one area that seniors cannot wait for is getting the prescription drugs.

Senator TALENT. Particularly for those with the greatest need. Along those lines, there will be an additional subsidy for low-income seniors. Now I have to preface this by saying that we are discussing what we think will be in the bill when it comes out of what's called a conference committee. But the details haven't actually been finalized, much less voted on by either House. However, this is what we expect.

There will be a subsidy of $600 to $800 for lower income seniors. Now what do we mean by lower income, what do you think the bill is going to have?

Mr. ALLEN. That is an area that is being worked out in the conference committee, we don't know that right now.

Senator TALENT. Right.

Mr. ALLEN. So that's one of the areas. But we do know that both in the Senate bill and the House bill, that there is clearly provision for a benefit of between $600 and $800. I believe the figure right now is $600, that low income will receive. But the question as to what qualifies as low income has not been finalized yet, and that is one of the issues the conferees are working through.

Senator TALENT. Well, I am going to stick my neck out just so you all get a ballpark figure and the percentage I have heard tossed around is 135 percent of the Federal poverty line, which would be roughly an income of about $12,000 a year for an individual.

Mr. ALLEN. That is correct.

Senator TALENT. Now it could be somewhat higher, somewhat lower than that, but that's the ballpark.

Mr. ALLEN. That has been——

Senator TALENT. Is that a fair ballpark?

Mr. ALLEN [continuing]. Pretty much, that is a fair ballpark I'd say, yes.

Senator TALENT. I am going to add one point about implementation because it's a little bugaboo of mine. I went back and looked up how long it took the government to institute all of Medicare in 1965 when it was passed, because we've said that system was great then, it's a little out of date now, we've been a little critical of it, and I think, properly so.

But they were able to get it all instituted in 8 months in 1965. It would seem to me that we could try to do this additional benefit inside of the 2 years that we are now planning.

Mr. ALLEN. Right. Right.

Senator TALENT. So I know that you will attempt to do that, and I feel like we should be able to.

Mr. ALLEN. Certainly. Senator, I think the point that you made at the outset, Medicare as we know it is 40 years old. The Centers for Medicare/Medicaid Services, they're using 40 years old software. I don't know of any major corporation in this country today—major insurer—that uses 40 year old software.

So there's a lot of work that has to be done and that's such reforms are necessary. So we will be working very diligently to get it done. That's why, again, the first part, the prescription drug card, will come on line within 6 months after passage. Then we've targeted 2006 for full implementation of the Medicare program.

Senator TALENT. OK. Well, it's good to give an outside date so people don't get disappointed, but I would hope we could do it faster than that. All right, another issue that comes up concerns a seniors keeping existing coverages, will the new program be voluntary?

So let's first ask a questions submitted by Velda O'Guard from Mexico, Missouri, Velda, where are you? Are you here today? There you are, ma'am. Thank you.

She asks—and this is a question I often get—if the bill passes, will it affect her Medigap insurance? Would you like to address Medigap/Medicare supplemental?

Mr. ALLEN. Certainly.

Senator TALENT. Tell us how you think it will affect that.

Mr. ALLEN. That is a question of great concern that many seniors that I have heard from as well, whether it will affect your Medigap Insurance, and the answer to it is that, most seniors who are currently receiving and utilizing Medigap Insurance will be unaffected at all by this.

However, there will likely be some changes for those seniors who get some of their insurance through private coverage. If you get some of your drugs through private coverage, you may be affected in your Medigap plan. But the way we are trying to structure the legislation and implement the legislation will be to your advantage.

It will work this way: while the final details are still being worked out, it is possible that the final bill will recommend some changes to Medigap plans that cover prescription drugs so that they better fit with the new coverage scheme. Therefore, the Medigap will be benefited to you, as a recipient, under the Medicare plan and having a Medigap plan will actually get an increased benefit through. So you should not be harmed, but you should actually be benefited is what we are targeting.

Senator TALENT. Working to make certain that any changes are favorable. It's like if the bank finds that you are out of balance, but it's to your benefit.

Mr. ALLEN. Correct.

Senator TALENT. I mean, that's the idea here. For example, Medigap options now, as I understand them, don't have very good catastrophic coverage, isn't that right?

Mr. ALLEN. That's correct, they don't have very good catastrophic coverage.

Senator TALENT. One of the emphasis here is that we need to protect seniors from catastrophic prescription drug costs. I mean, one of the things I want from this bill is that, once it passes, nobody will have to go to bed at night worried that if they get some new prescription or set of prescriptions, the cost will take all their savings away. That there will be great coverage on that high end.

Probably Medigap will be pushed more in the direction of providing good catastrophic.

Mr. ALLEN. That's right. I think, Senator, the point that you made is very clear, that the way that we are trying to structure this is that the benefits will be to your advantage rather than to your detriment. So if you can think of it as enhancing your benefits rather than taking something away from you, that's what we are trying to structure it as. But, again, this is all being worked out still in conference.

Senator TALENT. Now we have said several times—and this is something I insisted on from the beginning in discussions with everybody, and not just me—most of the Senators did as well —that this program be voluntary.

That people who want to stay in traditional Medicare coverage can and still get prescription drug coverage, and people who want

to take advantage of these new options can and will get prescription drug coverage.

One point I want to make to folks is that newly retired seniors in today's world are generally coming off of privately-sponsored health insurance that looks a lot more like what these new options are going to look like, then what traditional Medicare looks like.

If we want to give them the opportunity to stay in the kind of coverage they're used to, we have to be able to provide more choices because that's what they're used to. So I think this is the kind of situation where, if the Congress does this right, we'll find many seniors choosing to stick with the traditional Medicare because that's what they're used to, but then as folks retire over the years, more and more of them will go into one of those options because that's what they're used to. Would you anticipate that happening?

Mr. ALLEN. We do. In fact, one of the key issues is that currently about one in ten seniors currently receive their benefits through a private corporation plan.

Senator TALENT. That was going to be my next question, so why don't you go ahead and——

Mr. ALLEN. I think that's right.

I think your point is exactly right. Because of this, companies tend to be the larger firms, almost one in three Medicare beneficiaries is actually receiving their healthcare coverage from a former employer.

So we are looking at a number of issues here. There was recent study put out by the Employer Benefit Research Institute that completed analysis. What they had said is that they believe that it is possible that about 1 to 3 percent of all Medicare beneficiaries will be impacted by the changes.

What Congress and the administration are working to guard against, is having those private companies drop their coverage and therefore leave many of their employees in a lurch. So we are working very closely to ensure that that does not happen by giving incentives to employers to continue their coverage for their retirees by providing two options.

One option would be to either continue the primary drug coverage that the company has for their employees, or, two, to accept the new government subsidy by wrapping around the private employers coverage around the Medicare program.

So we are trying to minimize the impact of those individuals who will be retiring who have private company insurance coverage, so that they're not impacted adversely and that we also do not damage the work that's being done in the private sector because it's very important that insurance is far better than a government program.

Senator TALENT. Now on behalf of the Missourians I have talked to—and really for the record here since I get this question probably more often than any other because about one out of three people get some kind of benefit from the employer from which they are retired—how will the new benefit affect retiree coverage in terms of what the law may say and also employer practice. Employers may just say, oh well, now that the Federal Government's covering this, I am going to drop my coverage. I am glad you raised that issue.

We are caught in a tension because employees are dropping that coverage already.

Mr. ALLEN. Right.

Senator TALENT. If we don't do anything because we are afraid that if we do something, employers may drop the coverage, we'll be in a situation where we have no safety net as time goes on as more and more drop coverage.

Mr. ALLEN. Right.

Senator TALENT. Much less for the folks who don't have the coverage in the first place. So what we are trying to do—and this is going to be hard so—I will look at this very carefully when it comes out of the conference committee—is to try and structure this so that we can provide the benefit without giving any kind of great incentive to companies that are free to do so contractually to drop their existing coverage.

Mr. ALLEN. Right. I think that's exactly right, that we have to be very careful not to structure the benefit package so it provides an incentive for private employers to drop coverage, but at the same time does not prevent them from making business decisions and put their employees at risk—their retirees at risk—because it's a contractual obligation that has been to those employees.

Senator TALENT. Right. Where it is a contractual obligation, they have that protection. It is a concern, but I personally don't think it should keep us from moving forward.

Sarhonda Browne is here. Where are you, Sarhonda? There you are. Good to see you. She's from North View Village Nursing Home. I enjoyed my Saturday morning there. We had hot dogs and a little music festival. She's asking, how would the new Medicare prescription drug coverage benefit affect long-term care seniors, those in a long term residential care setting?

Mr. ALLEN. Those long term care residents in residential settings, if they are on Medicare, for example, if Medicare is supporting their stays in those facilities, they, too, will benefit by both the discount drug card.

But more specifically because they're low income, they will be benefited by the direct subsidy, the $600 to $800 subsidy, that will be provided in terms of drug purchasing power that they'll be provided.

So if they're already participating in the Medicare program, receiving those benefits, those will be their benefits as well, enhanced under the program. So it will be consistent with what we are doing across the board.

Senator TALENT. Yes, my understanding as we debated this bill is that those residents will benefit like others who are under Medicare, so they'll get whatever additional benefits that they can get.

Mr. ALLEN. Exactly.

Senator TALENT. The bill does not itself contain anything extra for them as residents of a long-term care facility. Now earlier in the year, when Congress resolved the budget issues, you probably recall Congress passed money through to state governments, and a large part of that money was passed through for Medicaid, which is where most of those residents, of course, get most of their governmental support. Not all of that, what was passed through for Medicaid, ended up going into Medicaid, as you know.

Mr. ALLEN. Exactly.

Senator TALENT. But that was the intention at the time, that that money—and there was a considerable amount of money—be used to help residents at that time.

Mr. ALLEN. Right. The Medicare reform does not address that in that regard. At least not so far as from the conference committee that we've seen.

Senator TALENT. I'll tell you another question I get from folks, as seniors and as taxpayers, is what's the final cost of the legislation going to be? You know, can we afford it? This is a good question. Let's hear your response and I'll tell the folks I see.

Mr. ALLEN. The President has stated very clearly that the program will be $400 billion over 10 years, and this represents a significant expansion of the Medicare program thus far. In fact, it's about a 10 percent increase over the current projected Medicare spending. At the same time, it will not cover all of the projected drug spending over the next decade, so we will be looking at that.

It's important that any final program is targeted to those seniors who need it most and who need the most help, low income seniors, those with lower incomes and those with higher drug costs, while providing some relief for all seniors who want to enroll.

So we are trying to make sure that we are addressing across the board seniors, but, again, our focus will be on low income and those who have the highest drug costs.

It is also important that this benefit expansion be coupled with the reforms that are necessary. That's what we are trying to be very careful about, is making sure that we are providing the prescription drug coverage, but the reforms that are necessary to ensure the longevity of Medicare and the stability of Medicare and to the future for the next generation of those who will be retiring, those with disabilities that will be needing the program.

So those are the areas that we are—but the dollar figure that we are looking at, and continue to stick by, is the 400 billion over 10 years.

Senator TALENT. That money has been budgeted. This is a fair question, and I think that of all people, seniors know what it's like to be on a budget. They are often the ones that ask the question. There are three responses that I give them, and part of it is what you say. First of all, that's one of the reasons why it is important that the benefit target the assistance, so that while everybody will benefit, those who are the neediest, who have the highest drug costs or the lowest income would benefit the most from the bill. Both the Senate and House bills do that.

But everybody is going to benefit, and there's no reason why you can't when you have a pool as big as the pool of Medicare recipients. It should be possible to put together plans that really take into account the deficiencies of that kind of a big purchasing pool.

The second point—and it is a kind of an emotional point with me but I have just talked to too many people, we are going to hear one of them in the second panel—there are too many people who really are choosing between other vital needs and their health. They're skimping on their health.

The government undertook to provide this benefit 35 years ago. The rest of the health care world is updated, and it is time for the

Congress to do the same thing with Medicare. I mean, I think it's owing.

I also believe if it's done right, it may not cost that much, because if somebody is able to stay on a prescription drug program that keeps them healthy, they don't have to go to the hospital, which, by the way, Medicare pays for. So we can end up, in many cases, avoiding traumatic episodes that will cost us a lot more.

The other thing, and that's why it is key that we, at the same time as we provide the benefit, do it in the context of voluntary options that strengthen and improve Medicare. You mentioned this as well. Because the whole idea here is through competition and choices to make the dollars go further and still provide good quality healthcare. If we do that, then we help solve some longer-term problems with Medicare.

Mr. ALLEN. That's right. Senator, I think you are absolutely right in what you raise, and two points I would make about that. To give you some good examples, we continue to talk about the need to give voluntary options to seniors, those who would be personally in Medicare.

Well, one example of it is, is that while we think we can not only put out say $400 billion over 10 year, both the bills, the House and the Senate bill, contains a trust fund that would—the money would go into—that would be, in a sense, ensure that money would be available for that purpose.

But one of the things that, and why it's so important that we reform Medicare is make it modern, to update it. The keys to ensuring that we can bring down the costs of the services and the cost of, for example, prescription drugs, is by using modern techniques, disease management, addressing preventative care. These are issues that are going to ensure that seniors will have the available programs and services, but at the same time, help us to achieve those efficiencies across the board.

Two examples right here in Missouri I'll give to you that show you. Currently, under the traditional program Medicare, we don't cover diabetes management. This is a map of Missouri here that demonstrates across the board diabetes management. It talks about those counties in Missouri that are below the state average—are in the red—those that are below the national average are in the blue.

When you look at this, you'll see that diabetes management, by managing someone's diabetes, you have an opportunity to bring down the cost of care. Well, that currently is not provided under the traditional program. Under the enhanced Medicare program and Medicare Advantage program, these will be standard parts of the benefits that you would receive for diabetes management.

The same is true when you look at something like influenza and pneumococcal immunizations. Regular immunizations for pneumococcal and influenza should be standard practice for seniors. Currently, again, in the blue you see those areas where Missouri is below the national average. We are below the state average are the red counties.

Here's another example, by having options that are voluntary for those who choose them, can get these services as a standard part without additional costs to those beneficiaries.

Senator TALENT. When you're in Washington you'll often have people describe some additional benefit or something and say it'll really end up saving us money. After a while you get a little skeptical, but this is something that really can save money 5 percent of the folks in Medicare for those who get sick, cost us—isn't it about 55 percent of the cost?

Mr. ALLEN. Exactly.

Senator TALENT. Many of those folks have chronic diseases like diabetes and kidney disease where, in the rest of the health care world, insurance has adapted over time to emphasize more and more management, wellness, and prevention of traumatic episodes.

Mr. ALLEN. Exactly.

Senator TALENT. Traditional Medicare, as good as it is, just doesn't do that very well.

Mr. ALLEN. That's correct.

Senator TALENT. To the extent that we can get people into disease management coverages like that, we will save them ill health episodes and also end up making the system more affordable in the long run.

Senator Frist, who's the Senate Majority Leader, and I put a provision in the Senate bill that—you're aware of the pilot program?

Mr. ALLEN. Yes.

Senator TALENT. We believe so strongly in this—Senator Frist is a physician, and I have often been a patient, so we each have our own expertise in this area. We believe so strongly that we want to put more resources into identifying the high-risk type of cases and diseases and helping our hospitals and our doctors manage that care better in our patients. I hope we can save that provision in the conference committee.

Mr. ALLEN. Senator, just one last point on that, and to bring it home once again, and we are here at Harris-Stowe State College, and the importance that this has to communities of color.

The African American community, the Latino/Hispanic community, the Native American community, Asian American/Pacific Islander communities have a great disease burden in terms of the diabetes, cardiovascular disease, cancer, all of these different diseases, and what these maps show, and what we do know, is that many of these individuals benefit from Medicare, and yet their the ones who need the greatest choice.

So, therefore, when we talk about Medicare reform, we are also talking about closing the health gap and ending healthcare disparities. That's why I take it personally as a mission on behalf of the Department, the Secretary, the President, to talk in communities of color, to raise this issue that we need to be getting behind Medicare reform now because it's our people, it's our families, it's our loved ones who are bearing the disease burden here.

Giving them the choices and the options to have access to quality care that they choose is a vital issue of great importance to all of us because if we help those who carry the greatest disease burden, we are helping all of us because it increases all of the quality of health that we all have.

Senator TALENT. Well, Secretary Allen, I think I'll let you have the last word. I know you have to go and catch a flight, but thank you for being here. I think it was informative.

We are going to have our second panel, and I want to emphasize, again, that I'll be around afterward to visit with folks personally. So why don't we take a 5-minute break while we assemble the next panel.

Mr. ALLEN. Thank you, Senator. [Recess.]

Senator TALENT. We are reconvening the hearing and will go right to our second panel. I will just briefly reintroduce them, they will give their statements and then we will ask some questions.

Our first witness is Ron Levy. As I mentioned earlier, Mr. Levy is the Regional President and System Vice President of SSM Health Care, St. Louis. He's also going to speak on behalf of the Missouri Hospital Association, which represents 140 Missouri hospitals and health systems.

In his position with SSM, Mr. Levy oversees 1700 physicians and 10,400 employees who work in seven hospitals, three medical groups and a managed care organization. He has a distinguished 27-year career with SSM Health Care.

He currently serves on the boards of the Missouri Hospital Association's St. Louis Regional Health Commission, the St. Louis ConnectCare and a variety of community service organizations, including Catholic Community Services.

He is going to describe for us how he thinks the Prescription Drug and Medicare Improvement Act of 2003 will benefit hospitals and the patients they serve, and discuss any concerns that he may have as well.

Thank you for being here, Mr. Levy. Please, give us your statement.

STATEMENT OF RON LEVY, PRESIDENT AND CEO FOR SSM HEALTH CARE, ST. LOUIS, MO

Mr. LEVY. Thank you, Senator Talent, and thank you for the opportunity to testify here today. SSM Health Care is very proud to the be the first ever healthcare provider to win the nation's highest quality award, and that's the Malcolm Baldrige National Quality Award. This award was presented to SSM this past May by Vice President Dick Cheney and the Secretary of Commerce, Don Evans.

SSM Health Care, our national system, has more than 23,000 employees dedicated to caring for patients and their families in four states, Illinois, Missouri, Oklahoma and Wisconsin, where we also operate not just hospitals, but long term care facilities and home health agencies.

In 2002, our healthcare system discharged more than 170,000 people and provided more than one million outpatient visits. Of those hospital discharges, more than 67,000 were Medicare beneficiaries. For SSM hospitals, that represents 40 percent of the care and service we provide to our patients is provided to Medicare beneficiaries.

As the Senator mentioned, I am also representing the Missouri Hospital Association here today, and the MHA has been serving Missouri hospitals for more than 80 years. The Association currently represents 141 hospitals. It counts among its membership all the licensed Community Acute Care Hospitals in the State of Missouri.

SSM Health Care and the Missouri Hospital Association are pleased to express support for Senate Bill 1 and the Prescription Drug and Medicare Improvement Act for 2003.

In times of need, Americans depend upon the promise of hospitals to be there 24 hours a day, 7 days week should any healthcare need arise. Medicare beneficiaries are no different and now, by this bill, those beneficiaries will enjoy an enhanced quality of life as a result of this additional benefit. The Medicare program should enjoy savings as a result of drug therapies that will reduce hospital admissions and lengths of stay.

The payment updates included in Senate Bill 1 are more important than ever before for our nation's hospitals and our hospitals here in Missouri. The adequacy of Medicare payments is especially important as society takes steps to promote further competition in the healthcare marketplace, and as we also experience additional regulation in an effort to contain healthcare cost.

Adequate payments will help hospitals invest in the latest technology and sustain a professional workforce to most efficiently deliver the needed services.

Moody's Investor Service recently forecast greater credit volatility for not-for-profit hospitals and health systems in the future citing the luminous financial challenges, including the rising healthcare cost for our labor and benefits to our employees, the increasing cost of drug supplies that we provide to our patients, such as the new drug alluding stint for cardiac catheterizations. Obviously, we are facing a major increase in medical liability insurance. So these costs are having a major impact on our healthcare delivery system today.

Senate Bill 1 does assist hospitals in a number of ways, and these include the following:

First, by providing a full market basket update and payment for hospitals for the first time in almost 20 years.

Second, eliminating the disparity between small urban and rural hospitals and large urban hospitals by equalizing the inpatient base payment.

Third, by eliminating the cap on small urban and rural hospitals that qualify for a disproportionate share of hospital payments.

Fourth, improving and expanding the critical access hospital program.

Fifth, by restoring a more reasonable indirect medical education payment for our teaching hospitals.

Sixth, provision of payments for rural home health agencies and many other supportive provisions.

I'd like to highlight a few of these important provisions in a little more detail. First, our inpatient services. According to the American Hospital Association, Missouri hospitals stand to gain $530 million in new funding because of this bill over the period of 2004 to 2013. The additional sum set forth in the Senate Bill will go a long way to help seniors receive the inpatient care that they need and we support.

Regarding rural hospitals. The Senate Bill provides about $25 billion over the next 10 years to increase Medicare payment to rural hospitals and physicians starting in 2005. As rural hospitals struggle to survive—and I know because I used to be a rural hos-

pital administrator in a previous life—we appreciate the language in a Senate Bill that eases the disparity between Medicare reimbursements for rural and/or urban hospitals.

There's also a temporary fee increase for rural ambulance services that are currently stretched thin.

We note——

Senator TALENT. Let me jump into clarify while it is fresh in the minds of folks who are listening. These updates for rural hospitals—maybe you could describe why they are necessary and comment on this.

For years, the government's reimbursement for rural hospitals has been based on the assumption that their costs are less than for urban hospitals, which in some areas is true but increasingly in other areas they are not. So they're actually getting less than hospitals in other areas are getting.

So this update really just brings them up to where the other hospitals are. Do you want to elaborate on that a little bit?

Mr. LEVY. Yes, and actually, why my current expertise is probably more urban oriented——

Senator TALENT. Right.

Mr. LEVY [continuing]. But I do remember—and it has been an issue for a number of years. Just as you said, Senator, rural hospitals, while we think they may cost less in their care delivery, they have other challenges; economies of scale, they pay the same prices for drugs and supplies—in fact they may pay more because they don't have access to large purchasing groups, et cetera.

So their costs of care delivery has escalated at a similar, if not a greater rate, than urban hospitals.

Senator TALENT. It may cost them more, not less, to get physicians practicing in that area, for example.

Mr. LEVY. Yes. The ability to bring them up to a level of payment that is at or equal to the urban counterparts, is a very positive thing to do. We have to realize that rural hospitals are really the fabric of our rural communities; we can't afford to see any further closure or diminishing levels of service they provide in those communities.

Senator TALENT. Thank you for that clarification.

Mr. LEVY. I was just going to say that Senator Talent is a strong supporter of full funding for rural hospitals and I think you can see that and hear that, and we do appreciate your efforts, Senator, to maintain these rural health provisions as the bill moves through Congress.

Regarding indirect medical education. There's also a small increase in the Senate Bill in subsidies for teaching hospitals. Every state has a teaching hospital, and the indirect medical education dollars are essential to training physicians in the future.

Missouri currently has 32 teaching hospitals, including two within SSM, SSM Cardinal Glennon's Children's Hospital and St. Mary's Health Center in Richmond Heights, which also receive the indirect medical education funding. This provision would allow millions of more dollars to flow to Missouri to help train physicians of our future.

Senator TALENT. That's crucial for Missouri indirect medical education—the extra costs that hospitals have for teaching residents

and medical students. At the same time that physicians are providing care, residents and interns that go around with the physicians during their rounds and that costs money.

Yet teaching is essential to the quality of the whole healthcare system. We have a disproportionately large number of teaching hospitals in Missouri, so this is a very important provision for Missouri.

Mr. LEVY. It is, and I think at the same we are very fortunate in Missouri to have the number of teaching hospitals we do.

Senator TALENT. Oh, yes. It's a real plus.

Mr. LEVY. Because it can provide additional physicians for us in this state.

Senator TALENT. Yes.

Mr. LEVY. Regarding disproportionate share payments, both bills increase the funds that states would be allotted under Medicaid for hospitals that treat a disproportionate share of the poor, starting in 2004. Again, Senator Talent, we appreciate you signing on a bipartisan letter to the Medicare conferees in support of the increase disproportionate share adjustment.

The Medicare statute requires that states make DISH adjustments to the payment rates of certain hospitals treating large numbers of low income and Medicaid patients. DISH payments help reimburse hospitals' costs for treating Medicaid patients, particularly those patients with complex medical needs, such as those duly eligible for Medicare and Medicaid, and make is possible for communities to care for those who lack health coverage.

Missouri would receive approximately $67 million in fiscal year 2004 and $57 million in fiscal year 2005 under the proposal advocated in our letter.

In conclusion, all in all, we believe that the Prescription Drug and Medicare Improvement Act in 2003 and the Senate Bill 1 that was passed in the Senate will benefit hospitals, will benefit our senior citizens by providing them with the hospitals with increased reimbursement and flexibility to manage patient care, and certainly help our senior citizens in paying for the care and drugs they need.

What this means is that hospitals like SSM will have more opportunities to help patients and/or community through improved service, which is one of the hallmarks of quality of care.

Again, I thank you for the opportunity to testify today.

Senator TALENT. Thank you, Mr. Levy, and we will probably have a couple more questions after the other witnesses are finished.

[The prepared statement of Mr. Levy follows:]

TESTIMONY
SENATE SPECIAL COMMITTEE ON AGING
AUGUST 27, 2003
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Mr. Chairman, I'm Ron Levy, President and CEO for SSM Health Care – St. Louis, and also the Regional President for SSM Health Care our national system. I am currently a member of the Board of Trustees for the Missouri Hospital Association.

SSM Health Care has been named the first-ever health care provider to win the nation's highest honor for quality achievement, the Malcolm Baldrige National Quality Award.
The award was presented to SSM Health Care for its exemplary achievements in the areas of leadership, strategic planning, customer and market focus, information and analysis, human resources, process management, and results.

According to a written statement by Health and Human Services Secretary, Tommy Thompson, SSM's "work with patient feedback and physician communications make it an outstanding example of what can be done when fresh thinking and modern science are brought to the delivery of health care in America."

SSM Health Care employs more than 23,000 persons dedicated to caring for persons in Illinois, Missouri, Oklahoma, and Wisconsin where the system operates hospitals and long-term care facilities. In 2002, our health system discharged over 170,000 persons and carried out over 1.0 million outpatient visits. Of those discharges, over 67,000 were Medicare beneficiaries: Missouri acute Medicare admissions as a percent of total Missouri admissions are 38 percent. SSM Health Care St. Louis represents approximately 50 percent of SSM national.

I am also representing the Missouri Hospital Association today. MHA has been serving Missouri hospitals for 81 years. The association represents 141 hospitals and counts among its membership all the licensed community acute care hospitals in Missouri.

SSM Health Care and the Missouri Hospital Association are pleased to express support for S.1, the Prescription Drug and Medicare Improvement Act of 2003.

In times of need, Americans depend upon the promise of hospitals "to be there 24/7" should any health care need arise. Medicare beneficiaries are no different and now, by this bill, those beneficiaries will enjoy an enhanced quality of life as a result of this additional benefit…and, the Medicare program should enjoy savings as a result of drug therapies reducing hospital inpatient admissions and/or lengths of stay.

The payment updates included in S.1 are more important than ever. The adequacy of Medicare payments is especially important as society takes steps to promote competition in the healthcare marketplace in an effort to contain healthcare costs.

Adequate payments will help hospitals invest in the latest technology and sustain a professional workforce to most efficiently deliver needed services. Moody's Investor Service recently forecast greater credit volatility for not-for-profit hospitals and health systems in the future, citing looming financial challenges including rising costs for labor and benefits, drugs and supplies, such as the new drug eluting stents used in cardiac catheterization procedures, medical liability insurance, etc.

Senate Bill 1 assists hospitals in this challenging economy by:

1. Providing a full market basket update for hospitals, the first in almost 20 years;
2. Eliminating the disparity between small urban and rural hospitals and large urban hospitals by equalizing the inpatient base payment.
3. Eliminating the cap on small urban and rural hospitals that qualify for disproportionate share hospital (DSH) payments.
4. Improving and expanding the Critical Access Hospital program.
5. Restoring a more reasonable indirect medical education payment for teaching hospitals.
6. Provision of payments for rural home health agencies, and many other supportive provisions.

Highlighting a few of these important provisions may be helpful.

Inpatient Services: According to the American Hospital Association, Missouri hospitals stand to gain $530.1 million in new funding over 2004-2013 under Senate Bill 1. The additional sums set forth in the Senate bill will go a long way to help seniors receive the inpatient care that they need, and we support including them in the conference report.

Rural Hospitals: The Senate bill provides about $25 billion over ten years to increase Medicare payments to rural hospitals and doctors starting mostly in 2005. As rural hospitals struggle to survive, we appreciate the language in the Senate bill that eases the disparity between Medicare reimbursements for rural and urban hospitals. There is also temporary fee increase for rural ambulance services that are stretched thin. We know that Senator Talent is a strong supporter of full funding for rural hospitals, and we appreciate his efforts to maintain these rural health provisions as the bill moves through Congress.

Indirect Medical Education: There also is a small increase in the Senate bill in subsidies for teaching hospitals. Every state has a teaching hospital, and IME dollars are essential to train physicians. Missouri has 32 teaching hospitals, including SSM St. Louis' Cardinal Glennon Children's Hospital and St. Mary's Health Center, which receive IME funding; this provision would allow millions more dollars to flow to Missouri.

Disproportionate Share Payments: Both bills increase the funds states would be allotted under Medicaid for hospitals that treat a disproportionate share of the poor, starting in 2004. We appreciate Senator Talent signing a bipartisan letter to the Medicare conferees in support of the increased disproportionate share (DSH) adjustment. The Medicaid statute requires that states make DSH adjustments to the payment rates of certain hospitals treating large numbers of low-income and Medicaid patients. DSH payments help reimburse hospitals' costs of treating Medicaid patients, particularly those with complex medical needs such as those dually eligible for Medicare and Medicaid, and make it possible for communities to care for those who lack health coverage. Missouri would receive approximately $67 million in FY04 and $57 million in FY05 under the proposal advocated in our letter.

Conclusion: All in all, we believe that the Prescription Drug and Medicare Improvement Act of 2003 (S.1) that was passed in the Senate will benefit hospitals by providing them with increased reimbursement and the flexibility to manage their patient care.

What this means is that hospitals like SSM will have more opportunities to help patients and our community through improved service, which is one hallmark of quality care.

Thank you for the opportunity to share our views today.

Senator TALENT. Now a real treat for the Committee: Audrey Vallely is here to testify. As I mentioned earlier, Audrey is a St. Louis senior citizen who is currently on Medicare. She is the mother of two and a grandmother of four. She currently lives in Pacific, where I have discovered we have several good mutual friends. She lives across from her great-granddaughter.

Like many seniors, Audrey's on limited income and has difficulty paying for her prescription drugs and doctor bills because the current Medicare benefit is simply not generous enough. She's told me that sometimes she doesn't take her medicine for her ailments because she can't afford to pay for them.

Today she will share her experiences as a Medicare beneficiary and explain why she's hopeful that the improvements in Medicare will benefit her and other seniors, and also any concerns she may have.

Audrey, thank you for coming and sharing with us. Please, give us your statement. Thank you.

STATEMENT OF AUDREY VALLELY, SENIOR CITIZEN, PACIFIC, MO

Ms. VALLELY. Thank you. Good morning. My name is Audrey Vallely. As Senator Talent said, I live in Pacific. I am the mother of two children, who are with me today; the grandmother of four children; and the great-grandmother of a new baby girl. I am also a senior who is enrolled in the Medicare program.

I have been on Medicare since I was 62 years old, and I am proud to be 77 today. I have osteoarthritis, a degenerative bone disease, and another sinus disease called Meniere's that causes me to become dizzy. I had an operation for the sinus condition, but the dizziness returns from time to time.

I should be taking at least two types of prescription drugs for these conditions. My medicine costs over $100 a month for maybe 15 pills. Because I am living on a limited income, I cannot afford to pay for these medicines. Instead, I go to my local pharmacy and take over-the-counter pain relief. Sometimes that makes me feel better, sometimes it doesn't.

I know I should see my doctor for these conditions, but I simply cannot afford to do this as often as I want. One office visit costs me $107. I know that I am lucky that my health is not bad, especially as some of my friends with diabetes and cancer pay over $200 or $300 a month for just their medicines.

Still, sometimes it is a choice between buying prescription drugs or paying rent, buying food or just living with air conditioning in the summer. Also, I have to drive to the doctor and gasoline costs $1.74. It goes up and down.

Everyday I am hopeful that Congress will pass a meaningful prescription drug bill to help me and other seniors. I understand that the bill now in Congress will help lower my prescription drug costs, and the cost of my doctor's visits to give me enough money to live on.

I also like that I'll be able to go to my pharmacist if I need to refill a prescription. Anything you can do to lower my price of prescription drugs and doctor's visits will go a long way to help me and my friends at the Route 66 Senior Citizens home in Eureka.

Thank you very much for letting me be a part of your program today.

[The prepared statement of Ms. Vallely follows:]

Statement of Audrey Vallely

Senate Special Committee on Aging
Field Hearing at Harris-Stowe State College

"Enhancing Medicare for the 21st Century:
A Prescription Benefit for Senior."

August 27, 2003

Good morning. My name is Audrey Vallely and I live in Pacific, Missouri.

I am the mother of two children, the grandmother of four children, and the great grandmother of a baby girl.

I am also a senior who is enrolled in the Medicare program.

I have been on Medicare since I was 62 years old and I am proud to be 77 today.

I have osteoarthritis, a degenerative bone disease and another sinus disease called Minera that causes me to become dizzy.

I had an operation for the sinus condition but the dizziness returns from time to time.

I should be taking at least two types of prescription drugs for these conditions.

My medicine costs over $100 a month for maybe 15 pills.

Because I am living on a limited income, I cannot afford to pay for these medicines.

Instead, I go to my local pharmacy and take over-the-counter pain relief pills.

Sometimes this makes me feel better, sometimes it doesn't work at all.

I know that I should see my doctor for these conditions but I simply cannot afford to do this as often as I want.

One office visit costs $107 dollars.

I know that I am lucky that my health is not bad as some of my friends with diabetes or cancer. They pay over $200 or $300 a month just for their medicines.

Still, sometimes it is a choice between my buying prescription drugs or paying rent, buying food or just living with air conditioning in the summer.

Also, I have to drive to the doctor and gasoline costs about $1.74.

I am hopeful that Congress will pass a meaningful prescription drug bill to help me and other seniors.

I understand that the bill now in Congress will help lower my prescription drug costs and the cost of my doctors visits to give me enough money to live on.

I also like that I will be able to visit my local pharmacist if I need to refill a prescription.

Anything you can do to lower my price of prescription drugs and doctors visits will go a long way to help me and my friends at the Route 66 Senior Center in Eureka.

Thank you for letting me be here today.

Senator TALENT. That was excellent, and just let me add, I am also a member of the Energy Committee, and your comment about gasoline and the price of it going up and down showed more common sense than I have heard in about 8 months on that committee, so I appreciate your contribution there as well.

Mr. Levy, I understand, has to leave pretty soon. Is that correct, Ron?

Mr. LEVY. That's OK.

Senator TALENT. Can you stay?

Mr. LEVY. Yes.

Senator TALENT. OK. Well, that's good, I don't have to reshuffle that, and we'll go right to Dr. DeFeo.

Our final witness is Dr. Frederick DeFeo who's the President of the Missouri State Medical Association, which represents 5,000 Missouri doctors. The MSMA's mission is to serve its members by promoting the science and art of medicine, protecting the health of the public and bettering the medical profession in Missouri.

Dr. DeFeo specialized in internal medicine. He's an Associate Professor of Medicine at the University of Missouri, Kansas City. He's here today to explain the concerns that doctors have with the current system, concerns he feels patients have, and how the Senate passed prescription drug bill might benefit them, as well as any other concerns that he may have.

We are very honored to have you with us. Thank you for your time, Doctor. Please, go ahead.

STATEMENT OF FREDERICK G. DEFEO, M.D., PRESIDENT OF MISSOURI STATE MEDICAL ASSOCIATION

Dr. DEFEO. Thank you, Senator. Medicare is 38. I remember the promise of President Johnson's great society, but, as a 19 year old, I was far more interested in the goings on in that little country across the Pacific. How different the world is today, and how different is medicine.

In 1965, when a patient had a problem, the standard was to admit that patient to the hospital, do appropriate tests resulting in a diagnosis, and then some kind of therapy. Now the hospital has almost become the venue of last resort and more work is done in the outpatient setting.

In 1965, chronic disease was likely to result in early death and disability. Even presidents with coronary artery disease were likely to have heart attack after heart attack. Diabetics developed blindness and died of kidney and heart disease. Chronic lung patients were admitted to hospitals in the fall and died in great numbers as colder air came in.

Now care of patients with chronic disease out of the hospital is standard. Heart disease patients live longer, more productive lives. Diabetics have preserved their sight and their kidneys, and chronic lung disease patients stay out of hospitals and breathe better.

In 1965, the paperwork burden for physicians was minimal. Now Medicare regulations seem more numerous than the tax regulations, and requirements for such unfunded mandates as the Advance Beneficiary Notice, the counting of points when I try to do a history and physical of a patient so that I can get the correct billing, and form after form after form that requires the physician per-

sonally to note such things as oxygen saturation and frequency of diabetic testing.

In 1965, the list of available pharmaceuticals was small, with the most expensive common drugs being the new antibiotics that might be used for a relatively short term for an infection.

Now we have new, more powerful and safer drugs for many chronic diseases, but they are far more costly and used for a far longer percentage of the patient's life span. But they better control cholesterol, diabetes, lung disease, hypertension, gastrointestinal disease, and even cancer with successful outcomes that were undreamed of in the 1960's.

The realities of the 21st Century show up in the design flaws inherent in this mid–20th Century program. Short term problems, financial hardships for many Medicare beneficiaries because of an antiquated cost sharing requirements. Without supplement insurance, the Medigap insurance, beneficiaries might pay more than $34,000 a year out of pocket. Who can afford that on a fixed income?

Fewer employers provide supplemental insurance as part of retirement benefits. The cost of Medigap insurance is rising, perhaps even faster than Medicare spending, and there is no coverage for prescription drugs.

Medicare beneficiaries are finding fewer physicians willing to provide care. Physician revenue, worse than hospital revenue, is generally decreasing because of such flawed ideas as the Sustainable Growth Rate formula, which ties physicians' payments to the economy, rather than the acuity of the patients they're taking care of.

Physician costs over all are increasing with very little ability for physicians to pass these costs on. Regulatory burdens drive physicians away. Audits for Medicare are so onerous that they may actually destroy a physician's practice.

Rural physicians and hospitals have significant payment bias against them in favor of urban. The best percentage in Missouri is still less than the one national average. The rural gets about .92, in St. Louis and Kansas City it's about .97, but still less than the one that's the national average.

Medical education, which at Truman Medical Center and UMKC I am long a part of, is being imperiled because of decreasing payments to our teaching hospitals. The long term problems. The funding for the current system is a tax-based, pay-as-you-go system, but the myth of a trust fund for all these years still persists.

Recent changes, rather than adding any new dollars to the system, merely cut the pie into more pieces, thus ensuring decreased payments for everyone. The solution is hard: modernize Medicare.

Reconfigure the cost sharing to a single modest deductible for all services, including those services not covered by Medigap insurance.

Add a pharmaceutical benefit designed to help those with catastrophic drug expenses. Decontrol prices. Consumer concern and competition should ensure lower prices in the long run.

Review, revise and simplify the regulatory burden for physicians and require that Medicare carriers give clear guidance for their

regulation. Reconfigure the basis for funding Medicare while there is still time.

The Senate passed Medicare bill is a good beginning. It provides the prescription drug benefit as has been described. If patients cannot afford to take their medication, then they will be admitted to the hospital for far more expensive after the fact care.

It provides some relief for rural hospitals, teaching hospitals, and hospitals in a critical area—and that's the Rural Equity Act, Senate Bill 816, co-sponsored by Senator Talent—eliminating the cap on small rural hospitals for disproportionate share programs, and establishing a floor on geographic adjustments for physician services, and increasing payments for health clinics, helping medical education and critical access programs by increasing payments for these areas.

It provides critically needed regulatory relief for physicians. Reforming the appeals process to simply the appeal of a Medicare denial of claim, streamlining the process for reviewing doctors' billing records, simplifying the process by which doctors correct Medicare billing mistakes and appeal actions against them, and exempting doctors for penalties when rules violation were the result of false written advice from the government.

Finally, the Senate resolution expressing the need to address the flawed physicians Sustainable Growth Rate formula should be a part of the final bill. Patients cannot see physicians who are not there. Medicare reform is necessary. The prescription drug benefit, regulatory relief, and help for our poorest hospitals and clinics will mean more patients with quality healthcare that is affordable.

Fixing the SGR formula will ensure physicians will be there to treat our elderly. Our seniors deserve no less. We will all join them far too soon. Thank you.

[The prepared statement of Dr. DeFeo follows:]

Draft of the testimony of
Frederick G. DeFeo, MD
President, Missouri State Medical Association

Medicare is 38! It was enacted in 1965 as part of President Johnson's Great Society programs as a contract for medical care for elderly Americans. The world is dramatically different in 2003 as is Medicine.

In 1965, when a patient had a problem, the standard was to admit that patient to the hospital and do appropriate tests, resulting in a diagnosis and some kind of therapy. Now, the hospital is almost the venue of last resort and work is done in the outpatient setting.

In 1965, chronic disease was likely to result in an early death. Even Presidents with coronary artery disease were likely to have heart attack after heart attack. Diabetics developed blindness and died of kidney and heart disease. Chronic lung disease patients were admitted to hospitals and died in great numbers as the colder air of fall swept the nation. Now, care of patients with chronic disease out of the hospital is standard: heart disease patients live longer, more productive lives; the sight and kidneys of diabetics are preserved much longer; and chronic lung disease patients stay out of hospitals and breath easier.

In 1965, the paperwork burden for physicians was minimal; now Medicare regulations are more numerous than tax regulations with requirements for unfunded mandates such as Advanced Beneficiary Notices, counting of points scored in a patient's physical exam or review of systems to allow "correct" billing, and form after form requiring that the physician personally note such things as oxygen saturation and frequency of diabetic testing.

In 1965, the list of available pharmaceuticals was relatively small, with the most expensive common drugs being new antibiotics that were used for relatively short terms. Now we have new, more powerful, and safer drugs for many chronic diseases, but they are far more costly than before and are used for a long time in the life of a patient. However, they better control cholesterol, diabetes, lung disease, hypertension, gastrointestinal disease, and even cancer with successful outcomes undreamed of in the 60s.

The realities of the 21st Century show up the design flaws inherent in this mid-20th Century program:

Short-term problems:

- Financial hardships for many Medicare beneficiaries because of antiquated cost-sharing requirements:
  - ~without supplemental insurance ("medigap" or Medicare), beneficiaries could pay more than $35,000 per year out of pocket;
  - ~fewer employers provide supplemental insurance as part of retirement benefits;
  - ~cost of "medigap" insurance is rising faster than Medicare spending;
  - ~there is no coverage for prescription drugs.

- Medicare beneficiaries are finding fewer physicians willing to provide care:
  - ~physician revenue (as opposed to hospital revenue) is decreasing because of such flawed ideas as the SGR (Sustainable Growth Rate) formula;
  - ~physician costs overall are increasing with little ability to pass these along;
  - ~regulatory burdens drive physicians away;
  - ~audits are so onerous that they may destroy a physician's practice;

- Rural physicians and hospitals have significant payment bias against them in favor of urban;

- Medical education is being imperiled because of decreasing payments to our teaching hospitals.

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- Long-term problems:
  - ~funding for the current system is a tax-based "pay as you go" system, but the myth of a "trust fund" persists;
  - ~recent changes, rather than adding any new dollars to the system, merely cut the pie into more pieces, thus ensuring decreased payments for older services.

- The solution is hard: modernize Medicare:

  - ~re-configure cost-sharing to a single, modest deductible for all services, including those services now covered by "medigap" insurance;
  - ~add a pharmaceutical benefit designed to help those with catastrophic drug expenses;
  - ~decontrol prices: consumer concern and competition should ensure lower prices in the long run;
  - ~review, revise, and simplify the regulatory burden for physicians;
  - ~require that carriers give clear guidance for their regulations; and
  - ~reconfigure the basis for funding Medicare while there is still time.

The Senate-passed Medicare bill is a good beginning.

It provides a prescription-drug benefit that focuses on prevention and treatment of chronic illness that otherwise would lead to disease states that Medicare would pay for after-the-fact at much higher cost; (Prescription Drug and Medicare Improvement Act of 2003 (S 1).

It provides some relief for rural physicians and hospitals, teaching hospitals, and hospitals in critical areas (Health Care Access and Rural Equity Act of 2003 (S 816), cosponsored by Senator Talent):
- ~increasing payment rates for low-volume hospitals;
- ~eliminating the cap on small urban and rural hospitals that qualify for disproportionate share programs;
- ~establishing a floor on the geographic adjustments for physician services; and
- ~increasing payments for rural health clinics.

It helps medical education and critical access hospitals by increasing medical education payments for our teaching hospitals and expanding the Critical Access Hospital program.

It provides critically needed regulatory relief for physicians:
- ~reforming the appeals process to simplify the appeal of a Medicare denial of claim;
- ~streamlining the process for reviewing doctors' billing records;
- ~simplifying the process by which doctors correct billing mistakes, appeal actions against them, and repaying Medicare when they over bill the program; and
- ~exempting doctors from penalties when rules violations were the result of false written advice from the government.

Finally, the Senate resolution expressing the need to address the flawed physician SGR formula should be a part of the final bill. Patients cannot see physicians who are not there.

Medicare reform is necessary. The prescription drug benefit, regulatory relief, and help for our poorest hospitals and clinics will mean more patients with quality health care that is affordable. Fixing the SGR formula will ensure physicians will be there to treat our elderly. Our seniors deserve no less. We all will join them far too soon.

-end-

Senator TALENT. Thank you, Doctor, that was a very compelling testimony. I have a few questions. We covered a fair amount of ground with Secretary Allen in terms of what the bill is designed to do, so I think I'll go a little bit into where we are currently.

Mr. Levy, maybe you could explain a little bit more the market basket issue that you raised. You mentioned that it hasn't been updated for 20 years. Now that's a phrase that's very well known to those in the field, and maybe not so well known to people outside it, so just say exactly what that means so that people understand how important that is.

Mr. LEVY. Essentially, it is the general rate increase that our hospitals will receive for the payments by patient. We have received increases, they've just not kept up with the rate of medical inflation or general inflation and so, when we use the market basket, does this basket of service keep up with the general inflationary trend.

This is the first time that I recall we are potentially going to receive a full increase of 3½ percent, which is roughly the rate of inflation, probably a little less than medical inflation, so that's the biggest increase that we've seen in years.

Senator TALENT. Audrey, I had a couple of questions which your testimony addressed. You talk about the choices that you are making because of the high cost of prescription drugs and the fact that you don't have any coverage in basic Medicare.

Of your friends who are also on Medicare, would you say the situation you're describing is common? Is it uncommon? Are most of your friends making those same kinds of choices or only a few? Give us a picture of what's going on. I know that you go to the Senior Center a lot, and you know a whole lot of folks so you're in a pretty good position to tell us this.

Mr. LEVY. Well, from just my——

Senator TALENT. Oh, I was asking Audrey, but then you can comment on it, Ron.

Mr. LEVY. Oh, I am sorry.

Senator TALENT. Unless you're going to the Senior Center a lot, too.

Mr. LEVY. No, no. I have gone to Senior Centers to visit. I am sorry.

Senator TALENT. So have I.

Ms. VALLELY. You are welcome to ours. From what I overhear, a lot of people in our Center, some of the husbands worked at the automobile factory, so therefore they have good coverage for insurance.

My insurance alone—I have ACF. ACF is no more. They turned it over to United Health, but United Health did not want to pay it anymore, so now I have to pay for United Health. So the insurance that my husband thought he was leaving for me, it's no more. OK, so I have to pay for that, plus pay for everything else.

Some of the ladies that come to the Center, that may be the only meal they get. They can pay $2 for a meal and get a good substantial meal, but it is a good meal.

Senator TALENT. It is pretty good. I have had those meals.

Ms. VALLELY. I mean, they try to give you a good meal.

Senator TALENT. Right.

Ms. VALLELY. They don't have transportation. When they go, they have to go on the bus, OK. Now a lot of those ladies that I had talked to, if they have a dental appointment, that means they can't go to the doctor in the same month because the dental problem is way up there and Medicare doesn't take care of that.

Another one has an ongoing—she has so many problems and she takes like 20 to 40 pills a day. Her children have to help her with that because her husband was a farmer and she does have Medicare, but there's not much else coming in.

Senator TALENT. You mentioned farmers. A whole other issue is farmers and small business people getting access to healthcare. They can't leave anything for widows if they don't have the health insurance themselves.

Ms. VALLELY. Right.

Senator TALENT. So you are one of those in a situation where you had, initially, some retiree health benefits through your husband and that was then ended.

Ms. VALLELY. I did have—the insurance and the Medicare took care of my husband. He had eight strokes, he had a stomach aneurism, he had five ruptured disks, he had all these and massive mastoid operation, two carotid arteries—they paid for that fine, with his insurance. We didn't have any out of pocket.

When he died, it took care of it, you know. But here I am and I have to go to a doctor that is—in Florida, where I lived, the doctor bill was $64 because my insurance never paid for the doctor's visits. Now it's jumped up to $107 here.

In Florida you could go to the little health centers and get most of your stuff done and it was like going to the emergency room, and then Medicare would pay for it. But up here you can't do that.

Senator TALENT. You raise a point that bears on this issue because if people have a chronic problem, we want them to be able to go in and see their physician as much as they need to. In fact, more up to date insurance coverages encourage people to do that because it actually saves money if they stay well.

But you——

Ms. VALLELY. Go to the dentist often.

Senator TALENT. Yes. That's another point. You've made the point that traditional coverage under Medicare actually is a disincentive to get that kind of regular wellness and consultation that keeps you healthy, and then you get sick, you go to the hospital, and Medicare has to pay a lot more.

So one of the things we want to do is give people choices that will enable them to stay healthy over time.

Ms. VALLELY. Also, may I point out, that the doctor that I go to is tied up with HMO. So he doesn't see you but every 3 months. When you go into to see him, he looks at you, sometimes he takes blood pressure, sometimes they weigh you, but it's still $107 for him to write out that little piece of paper.

Senator TALENT. Are you in Medicare+Choice, are you in traditional Medicare, what are you in?

Ms. VALLELY. I am sorry.

Senator TALENT. I am sorry, ma'am. Are you in a Medicare option, an HMO or are you in the traditional Medicare?

Ms. VALLELY. Oh, I am not in HMO.

Senator TALENT. That's right. So you're in the traditional Medicare.

Ms. VALLELY. Right. It's hard and it's hard on me. I make just so much money, half of what my husband was drawing. Together we were fine, but now that he's gone, I am very limited. Sometimes it is hard.

If you have to go to the dentist or the eye doctor—I was supposed to go to the eye doctor to check on my eyes in April. Well, I haven't gone because I had to go to the dentist, I had a broken tooth. That cost $900. I have—that's money, plus what my little dental insurance, 80 percent off, did.

What I want to know is, are we going to have a $250 deductible on all this insurance?

Senator TALENT. It's quite likely there will be a deductible, although it will be lower or won't be there if you are below a certain income level. What that income level——

Ms. VALLELY. Do you have to pay for it?

Senator TALENT. Yes, ma'am. There will be a deductible—I mean, I can't be absolutely certain, but I am 95 percent certain that the bill that emerges will have a deductible for seniors who are earning above a certain amount.

Now if you're below a certain amount, the deductible will essentially be gone. There may be a small co-pay. What exactly that figure's going to be, we are going to have to work on. It's hard to predict now.

Ms. VALLELY. Well, and sometimes——

Senator TALENT. You mentioned dental care. The House bill contains some provisions for a dental care option, the Senate bill doesn't. I agree with you—and we were talking before—that this is very common, periodontal disease is the most common disease, and we don't, as a system, do a very good job of taking care of it.

Ms. VALLELY. If you can't eat, if you can't use your teeth to eat, then you don't eat, which makes problems in your stomach, which sends you to the bathroom.

Senator TALENT. But the two most miserable common things to have are a backache and a toothache.

Because Audrey talked about emergency rooms, maybe you or Dr. DeFeo would tell us how a prescription drug benefit might take some of the strain off of emergency rooms in hospitals.

Dr. DEFEO. Well, I can tell you from the viewpoint of Truman Medical Center in Kansas City, which is the inner city hospital in Kansas City. Our emergency room was overflowing every day, and part of the reason are people who come in who cannot afford their medications.

Not just the senior citizens, but other indigent patients or—this is not for Medicaid, but that the Medicaid benefits for drugs have gone down so far, that they haven't met the other requirements for Medicaid. So this is an every day occurrence at Truman Medical Center.

Approximately, I would say, 5 percent of our admissions have to do with patients who could not get their drugs, and if they had gotten them, would not have been admitted to the hospital.

Senator TALENT. That's bad for them, but also our emergency rooms are under stress now. One of the reasons is that there are

a number of folks who are there who, we would prefer would get care some other way, because they don't have what we think of as a true emergency, but they are there because they don't have any other options. Would you——

Dr. DEFEO. That's correct.

Senator TALENT [continuing]. Agree, Mr. Levy?

Mr. LEVY. I would totally agree. One of the things that we've started to track very closely is the readmission rates for our patients to our hospital. Particularly our diabetic patients, congestive heart failure patients.

Generally if the cost is so high for the medications, as Audrey has so well described, and people aren't accessing the needed medications, particularly those that do have chronic disease, the formula is simple.

If it is a cost that is too high and it limits the access, the emergency rooms get busier, these patients wind up being readmitted to the hospitals, and it winds up costing us more for the care and treatment of those patients.

The bottom line is, it just complicates the care delivery for the senior citizens of our country. It is like playing a chord on a piano, but we are missing a few notes and the chord doesn't sound very good.

Senator TALENT. You are hearing from a couple of people who are not, speaking for themselves individually—it is not that these two gentlemen would stand to gain personally from this benefit, but the institutions or the systems that they represent is paying extra costs now in doing things that they would rather not do because a benefit doesn't exist.

Let me go into something that you mentioned, Dr. DeFeo, because it's a concern I have had, and I just don't think the average person is aware of it, and so I am going to be make a brief statement then ask you to comment. By the way folks, you've all been very patient and we are wrapping this up. I only have a couple more questions.

You mentioned regulatory reform for people in the system. Now what I don't want anybody in the audience to think is, OK, here's a doctor who's trying to get out of filling out some necessary form for quality or safety. The next time you're in to see your physician, ask him or her about this issue.

Ask to see the facilities—just to stick your head in and see what they have to do to maintain the records that are necessary to submit in the current system, many of which I just have to believe really don't do any good for anybody.

Another thing that's a concern. Several years ago, when I was in the House, I had some hospital officials come up to me and say that the government had claimed they had filed overcharges in Medicare amounting to several thousand dollars, and was now trying to recover criminal penalties of hundreds of thousands of dollars from this hospital, which is especially unfair when you figure that—I would guarantee you, if you were the most expert person in the world in filling out these forms for reimbursement, you would occasionally make mistakes because they're much more difficult than even tax forms.

We have some folks from CMS, which is the organization that runs this, and I want to say this on behalf of what you said. This is not a group of people who are trying to get out of legitimate responsibilities. Do you want to elaborate on that? Are you aware of the fact that the conference has reached some conclusions about reg reform, and I think they're going to keep all those Senate provisions in that you like.

Dr. DEFEO. I have heard that they had reached conclusions, I haven't heard what they're going to mean, yet. For instance, when I admit a patient to the hospital, in order to submit a reasonable charge, I have to document four, five things in one category, eleven things in a second category, nine things—kind of like a check list.

If you think of a typical high school dropout, they would say, OK, did he check A, B, oh, he missed D, there's F and G, oh, he didn't have eleven of them, so therefore the payment can't be X. It has nothing to do with the patient and his severity. It has to do with can I mark these boxes down. It's——

Senator TALENT. Then think of the time that physicians, who we want to be spending time with patients—Audrey, you mentioned that one. They didn't go to med school to sit around filling out forms. It is extremely demoralizing being in the profession.

Dr. DEFEO. I teach medical students and residents, I take care of patients, and it seems like I spend half my time filling out paperwork. We have a——

Senator TALENT. It may be. If not half, I bet it's close. So this is important, because we are all paying for this. We have a system where there's never enough hours to go around, so I get particularly upset whenever I see money being wasted. I mean, that gets us nothing. I am glad you raised that, and I think we are going to do something about it.

The funny thing is, all these voluminous forms do not keep that small percentage of the shrew corner cutters and the cheaters from cheating. They're still out there cheating. They find ways around it.

One other thing I wanted to raise, and maybe, Ron, you might be in a position to address this because you talked about reimbursement rates being driven down and held down. With the system that we have now, the government tries to figure out, based on its analysis, what a particular procedure should be compensated for.

I have now been around long enough, 10 years in the Congress, to constantly see situations where the government sets a price and somebody concludes, after a while, that it was too high, so people are making too much off of that, and then what the government will do is drop it like an ax. This happened in the home health business a few years ago.

It creates tremendous instability in the system and drives people out of business; or, and this has been more common, driving it down, down below what people need to get their cost, and then physicians and hospitals can't afford to take care of Medicare patients. Do you want to comment on this at all?

Mr. LEVY. I think that's an experience that has been ongoing for the last 20 years, ever since we implemented the system of payment called DRGs where you get paid by case. The concept is a

great concept, and for a while it really worked because the incentive is, how can we deliver care better and more efficiently.

At SSM, we really do believe it's not an either/or. We believe that the more we work on improving the quality of care by improving our work processes, by reducing our variation, by putting standards of care in place, when we do that, we do improve the quality, because we measure the outcomes, and we also become more efficient in the delivery of care.

But the more efficient we become in the delivery, instead of gaining that incentive of here is what you are going to be paid, that price has dropped.

Senator TALENT. Yes.

Mr. LEVY. There's nothing wrong with continual cycles of innovation, we have to continue to do that and continue to be efficient in our care delivery. It's gets to a point, when you add on the regulation that you're talking about in the paperwork, where difficult decisions are being made that you can no longer provide the service.

In St. Louis, I think everybody's familiar with what we face in North County with one of our hospitals, DePaul Health Center, making a decision that we might not be able to provide trauma care anymore.

Senator TALENT. Yes.

Mr. LEVY. I think that your point is an important point. If there is one thing that you could do, it is on the issue of regulation. I think we have to free up some of our time to be able to provide the care and service to our patients. Seventy-five percent of a nurse's time is paperwork.

Senator TALENT. Now, repeat that?

Mr. LEVY. Seventy-five percent of a nurse's time is paperwork. That's not what they're supposed to be doing. They're supposed to be at the bedside caring for the patient and working with our physicians.

The burden on physicians today and the burden on hospitals is—that's probably one of the many cost inflators, and so we have to continue to pay for nursing care, what our physicians do, technology changes and patients are sicker in our hospitals.

I think your point about not continually depressing or quickly dropping the prices—we have to have a sustained commitment to paying for the care of the elderly and the indigent in this country.

Senator TALENT. Thank you, and I raised that and I'll close now, because it bears on what we were discussing before when people ask about the cost of the prescription drug benefit. It really is true that if we can take steps to strengthen and improve the system at the same time we adopt this benefit, then we can get efficiencies, we can get savings that will free up a lot of dollars for this kind of care. They've just described some of them.

I am pleased and grateful to this set of witnesses, and if I may say so, especially to you, Audrey. I appreciate you coming. The other two gentlemen are honorable in their service, but you came a ways and I am grateful to you, grateful to everybody here in the audience and, again, to Harris-Stowe, thank you very much.

I will be available afterwards to visit with folks and discuss any concerns that you may have.

Thank you all for coming, I'll adjourn the hearing.

[Whereupon, at 11:55 a.m., the Committee was adjourned.]

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