Testimony of Leslie V. Norwalk
Acting Administrator, Centers for Medicare & Medicaid Services
on
"Boomers and the Budget: What Does it Mean for America's Seniors?"
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Good afternoon Chairman Kohl, Senator Smith, and distinguished members of the Committee. I am pleased to be here today to discuss proposals in the President's fiscal year (FY) 2008 Budget for programs administered by the Centers for Medicare & Medicaid Services (CMS) that impact seniors: Medicare and Medicaid. I would also like to highlight some of CMS' ongoing initiatives that improve seniors' lives, such as personalized assistance with new Medicare benefits, and a commitment to quality and transparency that empowers beneficiaries.

Ongoing Initiatives to Strengthen Medicare

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

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

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

We also are seeing exciting trends in the Medicare Advantage program. Through Medicare Advantage, beneficiaries have access to integrated health and prescription drug benefits, often with lower premiums and cost-sharing than under fee-for-service Medicare. Medicare Advantage is a particularly important program for lower-income Medicare beneficiaries, who might otherwise struggle with Medicare's cost-sharing or with supplemental insurance premiums that can be costly. Fifty-seven percent of beneficiaries enrolled in Medicare Advantage report income between $10,000 and $30,000 compared to 46 percent of fee-for-service beneficiaries.[2] Racial and ethnic minorities also benefit from the Medicare Advantage program; minorities represent 27 percent of total Medicare Advantage enrollment, compared with 20 percent in fee-for-service.[3] Enrollment in Medicare health plans has now reached an all-time high of 8.3 million beneficiaries, up from 5.3 million in 2003. In 2007, beneficiaries in all fifty states have access to Medicare Advantage plans – a significant improvement over the pre-MMA days.

FY 2008 Budget Proposals

CMS is the largest purchaser of health care in the world. Our programs provide health care coverage to about 92 million beneficiaries, almost one in three Americans. Combined, Medicare and Medicaid pay about one-third of the Nation's health

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

expenditures. In FY 2008, Medicare benefit costs and the Federal share of Medicaid and SCHIP benefits are expected to total almost $657 billion. Working closely with beneficiaries and providers, we believe we can improve the quality, efficiency and ultimate viability of the Medicare program.

Medicare Proposals

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

Recognizing the gravity of these warnings, the President's Budget strives to induce providers toward greater efficiency with payment policies that increase the role of competition and create a strong financial incentive for providers to slow cost growth through greater productivity and other improvements in efficiency. In addition to

[4] 2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds at pp. 3-4.
[5] Report to the Congress: Medicare Payment Policy at pp. xv; 6-8 (March 2006).

encouraging appropriate, high-quality care for people with Medicare, the proposals would reduce the growth in premiums for most beneficiaries. Under current law, and based on the Budget economic assumptions, the assets of the HI trust fund would start to decline in 2015; the Budget proposals would reverse that decline and increase the value of the HI Trust Fund throughout the ten-year window.

When combined with Medicare administrative proposals,[6] the FY 2008 Medicare legislative proposals including those described below would save $5.3 billion in FY 2008 and $75.9 billion over five years.[7] The net effect is a reduction of less than one percentage point in the rate of growth for Medicare over the five-year budget window. Medicare's current average annual growth rate over the next five years is projected at 6.5 percent per year. Under the President's Budget, that rate of growth would slow to 5.6 percent per year. Specifically, the Budget would:

- Foster Productivity and Efficiency: Responds to inefficient health care delivery and rapid spending growth with provider payment adjustments that would account for expected productivity gains and induce providers to achieve efficiencies that restrain costs;

- Rationalize Medicare Payment and Subsidies: Ties payment to reporting of medical errors and expands value-based purchasing for hospitals; encourages appropriate payment for five common post-acute care conditions; addresses excessive Medicare payment and beneficiary coinsurance for power wheelchairs and oxygen equipment;

- Improve Program Integrity: Facilitates proper coordination of benefits through improved data sharing; creates incentives for providers to recoup their debts;

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

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

strengthens the integrity of the administrative appeals process by limiting Mandamus jurisdiction as a basis for obtaining judicial review;

- Increase High-Income Beneficiary Responsibility for Health Care: Eliminates annual indexing of income thresholds for reduced Part B premium subsidies, and extends the income-related Part B premium adjustment to Part D premiums; and

- Improve Long-Term Sustainability: As a fall-back response if there is no Congressional action, applies a -0.4 percent sequester to the Medicare payment amount for all providers in the first year that general revenue funding for the Medicare program exceeds 45 percent. The sequester reduction would grow by an additional 0.4 percent in each successive year that the general revenue funding remained above 45 percent.

Medicaid Proposals

Many of the most vulnerable seniors also rely on Medicaid for help with Medicare premiums and other cost-sharing, and additional benefits. In 2006, 4.9 million Medicaid enrollees were aged 65 and over; an additional 8.3 million were blind and disabled. Collectively, these groups accounted for more than 25 percent of total Medicaid enrollment in 2006.

In FY 2008, we are proposing a series of legislative changes that will result in gross savings of $12 billion over the next five years, which will keep Medicaid up-to-date and sustainable for years to come. The Budget also announces plans for several administrative initiatives that achieve an additional savings of approximately $13 billion over five years. The President's FY 2008 Medicaid reform proposals would slow the average annual growth rate in Medicaid over the next five years from 7.3 percent per year to 7.1 percent per year.

Specifically, the Budget includes the following proposals:

- Long-term Care: Ensures that Medicaid long-term care services are protected for those who need it most by removing the state option to define substantial home equity between $500,000 and $750,000;

- Program Integrity: Improves Medicaid management that will help states avoid paying unnecessary costs through improved third-party liability reforms and more effective Medicaid eligibility processes;

- Pay-for-Performance: Requires states to report on performance measures and link their performance to federal Medicaid grants; and

- Pharmacy Reforms: Builds on reforms in the Deficit Reduction Act of 2005 (DRA) to further rationalize Medicaid payments for prescription drugs and to give states more private sector tools to manage drug spending;

- Reimbursement Reform: Aligns Federal reimbursement for administrative services and targeted case management to create consistency in matching rates across these activities.

In addition to these proposed initiatives, the Administration has implemented many of the reforms included in the Deficit Reduction Act (DRA) which was signed last year by the President. Provisions of the DRA represent the most important reforms in 15 years to end the longstanding Medicaid bias toward institutional care. Institutional care may still be the best choice for many, but the DRA helped make home- and community-based care a real option for Medicaid beneficiaries. The law created strong financial incentives and opportunities for States through options like Money Follows the Person and Cash and Counseling, which give disabled Medicaid beneficiaries, their caregivers, and families the ability to choose the optimal setting for long-term care needs.

Access Proposals

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

The Federal Government's current system of paying for health care results in billions of dollars being spent inefficiently through a patchwork of subsidies and payments to providers. In addition to directly funding the care provided to people enrolled in programs like Medicare and Medicaid, health care entitlement programs finance payments to institutions that either indirectly pay for uncompensated care or subsidize their operating expenses.

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

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

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

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

A New Paradigm: Personalized Assistance Supports Health Care Decision-Making

Along with the commitment to promoting long-term Medicare and Medicaid sustainability, it is a top CMS priority to change the way seniors make health care decisions. The unprecedented partnerships and outreach efforts that began in anticipation of the first Part D open enrollment period continue today and will be a permanent part of the Medicare program moving forward. CMS is working today with a strong network of

partners, including the Administration on Aging (AoA), the U.S. Department of Housing and Urban Development (HUD), and the Social Security Administration (SSA) to reach beneficiaries "where they live, work, play, and pray" as part of our transformation from health care bill payer to a public health agency.

In 2005, CMS built a network of thousands of partners, and hosted tens of thousands of events across the country. When the initial Part D enrollment period ended on May 15, 2006, more than 90 percent of people with Medicare had coverage for prescription drugs through Part D or another plan. CMS continued these outreach efforts throughout 2006, with the goal of educating every senior that they again had a choice to make about prescription drug coverage. "Prepare and Compare" was our mantra and people with Medicare did just that.

A CMS tracking survey indicated an extremely high level of awareness in Fall 2006, with more than half of our respondents having reviewed their current coverage -- specifically comparing premiums, deductibles or co-pays, and coverage levels. Medicare beneficiaries and those who care for them showed once again that they are informed consumers. More than 87 percent of all beneficiaries who enrolled in a prescription drug plan for 2007 have chosen a plan with coverage other than the standard benefit, such as no deductible, fixed co-pays, or coverage in the gap. Seniors seem to be thriving on choice in the Medicare program, and CMS is committed to providing the tools that are needed for beneficiaries to understand and evaluate their options.

Medicare also is working to change the health care decision-making paradigm for its beneficiaries, giving them new tools and creating a new environment that will allow them to make more informed choices about their health and take more action on their own to stay healthy. The community-based outreach that was part of the Part D enrollment process, the far-reaching partnerships, and unprecedented, personalized support for beneficiaries and caregivers will be permanent features of the Medicare program.

As an example, the *My Health. My Medicare* initiative is designed to help everyone with Medicare make the most of their benefits. Providing beneficiaries with personalized information—online, on the phone and in person—helps them understand and access new preventive services they may not yet be familiar with, and online comparison tools provide access to provider quality information and cost/coverage data.

CMS will continue to provide increased support to help seniors through 1-800 MEDICARE. The 1-800 MEDICARE line received 42.2 million calls in FY 2006 – nearly one call for every beneficiary and roughly two-times the FY 2005 volume of 21.8 million calls. High volumes continue in January 2007, 1-800 MEDICARE received 3,046,708 million calls. Available 24-hours a day, 7-days a week, 1-800 MEDICARE is unrivaled in its potential to answer seniors' health care questions anytime, no matter where they are.

Finally, in addition to reaching out to seniors, Medicare is using its sizeable presence in the healthcare marketplace to encourage greater awareness and use of preventive services and to facilitate a more quality-conscious, more transparent, and more collaborative health care environment. By facilitating information exchanges among beneficiaries and providers, CMS can reward smart decision-making with better care *and* lower costs.

Conclusion

In addition to proposals in the President's FY 2008 budget, CMS remains committed to a core mission to provide continuous quality improvement across all of our programs. Medicare is becoming a partner in helping seniors and people with disabilities stay healthy and make informed decisions about their health care needs. Medicare and its network of partners is delivering support, information, and personal assistance at the local and individual level – and this support is not going away. We look forward to working with Congress in the year ahead to improve and strengthen our programs, keeping our commitment to America's seniors today and for years to come.