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Statement of Rep. Henry A. Waxman
Chairman, Committee on Energy and Commerce
“Medicare’s Competitive Bidding Program for Durable Medical Equipment:
Implications for Quality, Cost and Access”
Subcommittee on Health
September 15, 2010

I thank Chairman Pallone for holding today’s hearing on this important topic.

The health reform legislation contains many essential innovations to improve the quality and efficiency of care in Medicare and the entire health care system.

Today we discuss an innovation that predates health reform – competitive bidding for durable medical equipment (DME).

The DME benefit in Medicare is an essential benefit for the nearly 10 million seniors who use it every year.

It pays for wheelchairs to help seniors and persons with disabilities move around their homes and communities.

It covers diabetic testing equipment so that beneficiaries can manage their condition and avoid kidney failure or heart disease.

DME is an indispensable part of an indispensable program.

And yet, for many years – nearly as long as I’ve been here, in fact – payments for DME in Medicare have been the source of seemingly endless problems.

DME has received some truly remarkable overpayments. Take, for example, Medicare paying 10 times the purchase cost for oxygen equipment.

And DME suppliers billing the program without even staffing their offices or documenting their claims gave us last year’s famous “60 Minutes” program on Medicare fraud.

These chronic problems are an embarrassment to a program that has been, and must continue to be, a model of efficient health care purchasing.

Many suppliers are legitimate, honest business people trying to deliver the best care they can to Medicare beneficiaries. Their reputations are unfairly tarnished by the behavior of some of the other suppliers.

Congress has acted many times to try to address these problems. Some of these reforms have been successful, and some of them are just getting started.

Competitive bidding for DME is a market-based, bipartisan idea.

It has been tested successfully in Medicare in demonstration programs under Presidents Clinton and Bush. And it was enacted for program-wide adoption in the Medicare prescription drug bill passed by a Republican Congress and signed by President Bush.

This current round of competitive bidding is a re-bid of Round 1, which was delayed in 2008. I supported that delay because of implementation problems identified at that time.

Acting under Congress's direction, the Centers for Medicare and Medicaid Services (CMS) made many improvements to the re-bid of Round 1. Those changes appear to have reduced confusion among suppliers, though not opposition.

I take seriously the concerns raised by the supplier community regarding potential threats to beneficiary access to high quality DME. Competitive bidding has been tested successfully in Medicare, but not on a scale as large as what the law requires CMS to implement over the next few years.

It is essential that we on this Committee continue to monitor developments in the competitive bidding program as it unfolds. That is why I appreciate Chairman Pallone's initiative to call this morning's hearing.

It is also essential that CMS aggressively pursue supplier and beneficiary education efforts in the time before January 1, so as to minimize disruption to care with the start of the New Year.

But I question those who say that we need to repeal the program now because of speculative threats to beneficiary access in the future.

Where is the evidence for such a threat? It is certainly not found in previous experience with competitive bidding in the Medicare program.

Tellingly, those most concerned about beneficiary access – the beneficiaries themselves, including AARP and the Center for Medicare Advocacy – support going forward with the program and vigorously monitoring its execution.

Based on what we've heard so far, it appears that the current round of competitive bidding will save beneficiaries significant amounts of money in cost-sharing and premiums.

Beneficiaries using oxygen concentrators over a 3-year rental period would save \$400. And the improvements made by Congress and CMS offer important guarantees that winning suppliers will be able to deliver items and services beneficiaries need.

For these reasons, I am cautiously optimistic that competitive bidding for DME may soon begin to finally achieve its promise of reducing Medicare spending while maintaining or improving the quality of care received by beneficiaries.

I'd also like to ask unanimous consent to add to the record this statement from AARP that supports competitive bidding so long as it does not compromise quality and access for Medicare beneficiaries.

I look forward to this morning's testimony.