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Opening Statement of Rep. Henry A. Waxman
Ranking Member, Committee on Energy and Commerce
“Dual-Eligibles: Understanding This Vulnerable Population and How to Improve Their Care”
Subcommittee on Health
June 21, 2011

I thank Mr. Pitts for calling today’s hearing, and for his collaboration in selecting witnesses to appear before us today. I look forward to our discussion of the very complex issues surrounding the health needs of people dually eligible for Medicare and Medicaid – the so-called “dual-eligibles”.

Providing for the health needs of dual-eligibles has long been a major issue facing both programs. By design, these individuals should have access to the best both programs have to offer – but too often, they struggle, fall between the cracks, and cycle in and out of nursing homes, hospitals, and specialty care, without receiving the coordinated, patient-focused care they deserve.

Dual-eligibles are not a homogenous group, but can be considered as several sub-groups. Some, such as Medicare beneficiaries eligible for Medicare by virtue of age and for Medicaid by virtue of low-income can be in their mid 60s and may not differ significantly from other Medicare beneficiaries in their need for care.

Others, however, such as adults under 65 with developmental disabilities such as cerebral palsy or intellectual disabilities, require significantly more care and resources to live their lives. Older Medicare beneficiaries with cognitive impairments such as Alzheimer’s are another significant, and very frail, subgroup – a group we are going to hear from today.

All of these individuals may require nursing home levels of care, or home-based support services allowing them to live outside of an institution.

A disabled person under the age of 65 cost Medicare and Medicaid between \$23,000 and \$84,000 in 2005, depending on whether he or she needed a nursing home stay.

This is very expensive, but not getting this care is worse, resulting in eroding health, trips to the emergency room, suffering for the patient and his family, and astronomical costs for the

patient and the taxpayer. These costs present both a challenge and an opportunity to develop and implement reforms that over time will simultaneously improve care while reducing costs.

The Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission describe how a lack of coordination between Medicare and Medicaid can create harmful and wasteful outcomes, and misaligned incentives. For example, a nursing facility may find it profitable to transfer a complex patient to a hospital, even if the facility is capable of managing that patient, because of different payment rates and benefit rules in each program.

This Committee has heard many times of the problems generated by pure fee-for-service medicine that provides no coordination of benefits. For dually eligible beneficiaries, those problems are multiplied because of their intensive care needs.

We face a multitude of challenges in improving care for dual-eligibles and in reducing costs to the taxpayer. But it's important that we don't rush into new programs with a purely budgetary focus. We should not assign a price tag to this population and then design the policy around it.

As we'll hear today, the best and most successful efforts to integrate care for the duals has been local, and it has often focused on a small group of beneficiaries. These programs have been built around intensive interventions by nurses, physicians, social workers, therapists, and others.

But these interventions can be difficult to scale up to large populations. I hope that we hear today about how Congress and the Administration can help speed that process to scale-up, but we must remain wary about grand promises regarding this decades-old problem.

We also have important opportunities to save money we are spending on dual-eligibles by examining drug rebates in Part D. I certainly hope the Committee will give a high priority to examining that in the future as well.

Providing better coordinated care and saving money are not mutually exclusive goals, and for the dual-eligibles, this may be the key to improved quality of care.