MLMedicare and Medicaid's 40th Anniversary Speech
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Thank you, Rick, for that kind introduction. Thank you all for being here this afternoon for this very special time in the Medicare and Medicaid programs….I also want to thank a few more people here. One of the main things I'm going to talk about today is partnership.

And with that in mind, I'd like to thank Senator Breaux particularly, who continues to show his bipartisan leadership with the Medicare RX Education Network, bringing together groups with very different political views to help everyone in Medicare. And Mary Grealey, with the Medicare Today Coalition. It's another group that's helping out at the state and local level, making sure that everyone in Medicare gets the information they need. And I want to thank Janet Trautwein of the National Association of Health Underwriters, who's also been extremely helpful to Medicare and, as you heard, is here today.

As many of you know, we're celebrating a couple of important birthdays on Saturday. Medicare and Medicaid turn 40. Now, 40, as I know, is a time when many people take a look at what they've accomplished in their lives. You decide what you've done right, what kind of legacy you might be able to leave.

Looking back, there is much to be proud of in the Medicare and Medicaid program. When President Lyndon Johnson signed the bill that created Medicare, he said it would protect Americans so illness wouldn't rob their savings, and in his words, so that they might enjoy dignity in their later years.

When President Johnson said that, only about half of older Americans had any health insurance. And only about one in four older Americans had protection against the high cost of hospitalization. The creation of Medicare in 1965 did ensure the dignity of Americans as they reached old age at that time, as President Johnson promised. For many millions of seniors and people with a disability since then who have counted on the program, that is a truly memorable accomplishment.

But in the 21st century, helping to pay the doctor and hospital bills isn't enough. Drugs and other preventive treatment accounts for more and more of what medicine has to offer, yet until recently, until that Medicare law, the Medicare Modernization Act, Medicare didn't really cover them. Now, as Medicare gets to its 40th birthday, we are adding this coverage. Instead of cutting pills and trying to find free samples or getting pills from who-knows-where, instead of skimping on medicines to pay the rent, seniors will have the dignity of putting down their Medicare drug benefit card at their pharmacy counter and getting the medicines they need.

Peace of mind from greater financial security and health care is a really important accomplishment at 40. And I'm going to talk a little bit about how we're on track to bring

President Johnson's promise of dignity up to date with up-to-date benefits. But at 40 years old, Medicare needs to aim higher than that. Today, Medicare can do so much more than give you dignity in old age.

First, it can help you take advantage of what modern medicine has to offer. Not just to keep you comfortable in old age, but to help you live a much longer and healthier and less infirm life. As Medicare and Medicaid hit 40, we can keep the promise of dignity, but we can aim higher in helping you get much better health.

Second, we can aim higher by supporting the partnerships that are essential today in getting better health. Like prevention-oriented health care today, the Medicare and Medicaid programs cannot be effective without partnership. A one-size-fits-all, government- dictated approach is increasingly out of line with the direction of more personalized prevention-oriented medicine.

These partnerships start with the people in our program, because we know that 21st century medical care means working with the patient to help them stay well, not simply coming in to pay the bills when they get sick. Any doctor knows you've got to work with patients so they understand their health, understand how their lifestyle affects their health, and understand what they need to do themselves to help avoid the complications that too often aren't prevented today.

And third, we need to support these new approaches to better care to keep Medicare and Medicaid sustainable, to keep it financially secure as the baby boom gets older. With many more beneficiaries using many more treatments, we simply cannot afford to spend by what some estimates amounts to as much as 30 to 40 cents on every health care dollar on treatments that may be unnecessary or on complications that could be prevented.

Health care can do more than ever before, but in terms of quality and preventing unnecessary costs, it's not doing as much as it should. And so Medicare and Medicaid must do more than just pay the bills.

Whether we are -- whether we or anyone else likes it or not, we are a public health agency. Because of our size -- over $500 billion in spending this year on the combined programs -- how we spend matters. It affects how our whole health care system works. And that system needs better support for high quality care. High quality care, the right treatment for each patient every time, is the only kind of care that we can afford anymore. To serve our beneficiaries and taxpayers, Medicare and Medicaid can't afford to aim for anything less.

Medicare has essentially operated on the dignity or paying the bills model for many of its first 40 years. Now there's no question that providing financial security from major health care costs when seniors get sick is really important for our nation. But again, we should be aiming higher, because medical care has come so far in 40 years.

Consider for a moment what happened to you in 1965 if you had a heart attack. If you didn't just die, you went to the hospital. There doctors basically made you comfortable. They gave you oxygen to help you breathe, nitroglycerine to lower your blood pressure and morphine to take away the pain.

Then they and their loved ones hoped for the best: that you would be able to survive with a diminished heart. That was the best you could hope for.

Forty years ago, Medicare was created so seniors could afford to get treated with this kind of dignity when they were ill. But since then, there's been nothing short of revolution in health care, and that includes a revolution in the health care for heart attacks. It includes now coronary care units to prevent death from heart failure and irregular heart rhythm, and better drugs to keep your heart working smoothly through the stress. And then thrombolytic drugs and angioplasty came along, treatments that head off the heart attack altogether.

So today, if you're unlucky enough to have a heart attack, you will get proven lifesaving care even before you arrive at the hospital. And once you get to the hospital, you can usually expect to recover to an active, high level of quality of life.

Of course, you shouldn't have to go to the hospital at all today, because today we can prevent many heart attacks from happening in the first place, with diet, exercise, modern medicines and, if necessary, medical procedures.

That's why today we are aiming higher that the support for dignity in old age called for 40 years ago. We are aiming for -- and often getting -- much longer, healthier lives. And aiming for better health increasingly requires aiming for greater prevention.

That's in many ways a change for Medicare. Until recently, up to as much as 95 percent of Medicare spending has gone to treating health problems after they happen -- paying for the additional office visits to the doctor or the emergency room or the hospital or the surgery or the rehab because something has gone wrong, it wasn't headed off, and the problem progressed. That's the case with heart attacks. It makes better public health sense and is a better way to spend the dollars to diagnose the heart disease early, to treat it effectively with medications and other steps that are proven to slow or prevent cardiovascular disease, and head off the heart attack in the first place. As another example, it just doesn't make medical sense or common sense to pay for the dialysis or the amputations or the heart surgery that will occur when diabetes isn't treated early and effectively.

That's why we absolutely had to add preventative benefits to Medicare with the new Medicare law.

Medicare now covers screening for cancer, thin bones, glaucoma, and this year, as a result of the Medicare law, we've added free screening for cardiovascular disease and diabetes. Medicare also now has a "Welcome to Medicare" comprehensive exam for all

of our new beneficiaries, and extra coverage for evaluating beneficiaries who are found to have problems on this initial comprehensive visit. We now cover counseling for smoking cessation too.

Medicare's preventive coverage now matches up better than ever with the recommendations of the experts. That's a historic achievement.

And for the reasons I just mentioned, I view prescription drug coverage as a critical preventive benefit as well. For many chronic diseases today -- and one day hopefully all diseases -- prescription drugs can slow or halt their progression.

Important as these Medicare benefits are, they aren't enough alone to bring the health benefits of up-to-date prevention to everyone in Medicare. This is where a greater focus on partnerships comes in, starting with support for partnerships for better health with our patients and extending to much stronger local health partnerships throughout the country.

Before I was in government, I practiced internal medicine. And as anyone who's ever treated or had a chronic illness knows, or anyone who's loved someone who has one, you can't get the full benefits of preventive care unless your patient is a partner in managing their disease. There are few feelings more pathetic in medicine, and in life, for that matter, than thinking about what better things might have been, and I had that feeling too often in my medical practice.

I remember one patient -- a really nice guy -- who breathed heavily with swollen feet, who showed up in one of my emergency room shifts with complications from his heart failure. This happens every day.

We got him stabilized, gave him a few free samples of drugs, and I remember looking at him as we were about to send him on his way. I just knew he wasn't going to fill the prescriptions I gave him; he didn't have any drug coverage, and I wasn't sure it would even matter even if he did. He told me that before he'd come in he hadn't taken his medicines because he wasn't sure what they were for, and he had forgotten what he was supposed to do if he started to gain a little weight or notice a little swelling. And he had just eaten some really salty pizza and had a smoke.

I looked him, as I've looked at many other patients, and thought to myself, this just doesn't have to happen. If only someone could explain to him in terms that work for him why his diet and exercise and other aspects of his lifestyle matter so much with heart failure; if only someone could help him understand why he needed to take each of his medicines and the early signs of his heart getting worse and what to do if that happened. If only. All of this might have been prevented, and that kind of support would have been much cheaper than what we were actually paying for. But I had a patient with a bleeding ulcer in the next room, and I had to go.

Part of aiming high in Medicare is up-to-date benefits, like coverage for screening tests that could've caught his heart problem before it progressed, and the drugs that could've kept him well. But that wouldn't be enough for this patient and millions like him.

Another part of making sure patients are aware of their conditions and giving them effective support so that they can take the necessary steps to maintain and improve their health. That's another critical part of modernizing the Medicare program. That means supporting better partnerships, not just paying for more care.

To make sure patients do get the right care and that our benefits stay up-to-date, we are focusing more and more on partnerships. No where is that more evident than with the new voluntary prescription drug benefit that Medicare will provide, on schedule nationwide, on January 1st 2006.

The drug benefit will provide help for everyone with Medicare. It will help regardless of your income and regardless of how you pay for your medicines now.

On average, if you're in Medicare, you'll get about $1,300 worth of help with drug costs, and substantial discounts on the drug prices because of robust competition among the drug plants that drive those prices down. If you have very high drug expenses, there's even more help. Medicare will pay 95 percent of your expenses after you spend $3,600, and that coverage never runs out.

There's extra help available to those with limited incomes. About a third of all Medicare beneficiaries have limited means -- incomes below about $20,000 a year for a couple and limited financial assets. If you're in Medicare and you fall into this category, Medicare will pay for about 95 percent of your drug costs on average. Generally, you'll pay no premium, no deductible, and co-pays of just a few dollars per prescription.

For everyone, whatever plan they're in will have to meet Medicare standards. Every plan will cover brand-name and generic drugs, and every plan must provide access to the drugs that are medically necessary. And seniors can get their medicines at a pharmacy that's convenient for them, generally within a few miles of their homes.

As most of you know, people with Medicare can begin signing up for this coverage on November 15th, and the sign-up periods run through May 15th 2006. But we're not waiting until this fall to get this program going. It takes a lot more than a few ads or speeches to help seniors make confident, informed decisions about their coverage.

Now, of course, we'll have specific information on our 24-7 customer service line -- that's 1-800-MEDICARE -- and on the Web at medicare.gov. But our effort is bigger and better than just that.

We're working with a very wide variety of groups and agencies as partners to provide personal support for people with Medicare and their families right down to the local level.

We're working with government agencies, such as the Social Security Administration and the Administration on Aging, with local offices and with staff all over the country. We're working with pharmacists and physicians and other health professional groups. We're also working with groups like the Access to Benefits Coalition, which is taking unprecedented steps to reach seniors with limited incomes. Their director, Jim Firman, calls the new drug coverage the most important new benefit for seniors in America with limited means in 40 years.

Our effort to educate and inform people with Medicare means we're going to connect with Medicare beneficiaries and their families where they live and work and play and pray.

The local and personalized support means people with Medicare can get information that is tailored to their individual situation. If you're a Medicare beneficiary, what you need to know about the new coverage depends on your circumstances. The drug benefit will work with how you get your health care now, whether it's from the original Medicare plan or if you get help from a former employer or if you have a Medicare Advantage health plan.

I want to be very clear. If you're a Medicare beneficiary, you do not need to know everything about the Medicare law to get help from the drug benefit. We are not making you pass a civics test.

Then starting with how each person gets their health care now, we will give our beneficiaries, their family members and their caregivers the opportunity to choose the coverage that's best for them. We're doing this in partnership with all of those organizations I mentioned, to provide the support people with Medicare need so they can get the prevention-oriented coverage that they need today, coverage that saves them money and never again will fall behind because the government can't keep up with what they want.

So, increasingly Medicare is focused on partnership. We are launching other programs to help people with chronic diseases get the support they need as well to use this new coverage effectively.

One of these initiatives is a pilot program, called Medicare Health Support, (which) starts this week. It will do what an effective health care system should do, strengthen partnerships to prevent the kind of the situations like the one I described in the emergency room.

These pilot programs will include support for patient education, reminder systems, home visits and electronic health records. The goal: helping people with heart failure and diabetes be more effective partners with their physicians in preventing the debilitating and costly disease complications.

It's important to note that heart failure and diabetes account for most Medicare costs. People with these condition account for most Medicare costs today. With Medicare Health Support, we're going to help them spend our money more effectively.

This is a really important point and it goes to the third higher aim that Medicare and Medicaid need to have today -- spending our money better so these valuable programs can keep going for the future.

With a growing senior population, we can't afford to simply keep paying the bills, even the bills for up-to-date benefits, if those benefits are provided in the same old way. But with modern medicine, Medicare and Medicaid can help provide better, more innovative care for less. We are failing to do this now.

When 50 percent of our beneficiaries do not get recommended preventive care, and over 45 percent do not get proven effective care for their illnesses, we are spending much more than we should on preventable complications and inappropriate care.

I talked earlier about how much better we are doing in treating heart attacks, yet we could be doing still better. This year tens of thousands of heart attack victims in Medicare will not get treatments that have been proven to prevent complications after heart attacks. And for decades, studies have shown that variations in medical practices around the country that increase costs without clear health benefits may make Medicare expenses at least 30 percent or more higher than they need to be.

Studies also show that over 30 percent of seniors get prescriptions that involve drugs or combinations of drugs that are generally contraindicated -- in other words, that conflict with each other and can actually make a patient sicker. We simply can't keep doing this and have a Medicare program that is up to date and sustainable.

I'm an economist as well as a physician, and I know that whenever it comes to money, you get what you pay for. And until now, what Medicare has done is pay more for more treatments, regardless of whether those treatments really made the patient better.

Our system is perverse. We'll pay more for more office visits and more tests, even if it's not clear that those visits or tests are effective. But we won't pay more if a doctor helps you be well enough that you don't have to make another appointment. We have a system that pays billions for many treatments year after year without ever really learning how well they work.

But right now we have an opportunity to reshape the way our health care system works, to improve care and make it more affordable for everyone. CMS, my agency, is the world's largest health care payer. So if we take the right steps to improve quality together, the Medicare law's impact will be felt not just in Medicare but throughout the entire American health care system.

This is what the new Medicare law is really about. It's about aiming higher for better health, and it's about aiming higher in how we pay for care, to focus on what really matters: supporting better quality and lower cost.

That's how the Medicare Health Support initiative that I talked about works. In this program, we are paying not for more medical services, but we're paying for better quality care, better satisfaction and lower costs. And that is what we're getting in the program.

The same thing is true in the Medicare Advantage health plans in Medicare, which give beneficiaries a choice about how Medicare pays for health care on their behalf. People can choose to get better benefits and lower costs from the coordinated care networks and other features of these programs, of these plans. These health plans include HMO and PPO -- preferred provider organization -- and fee-for- service options, for more comprehensive coverage with greater continuity. As more people start to choose these options, we're starting to see better care at lower total cost for the government and especially for our beneficiaries.

An increasing number of people in Medicare are choosing to have Medicare pay for their health benefits in these Medicare Advantage plans, in part because of how these plans spend the money. They offer better benefits and average savings of about a hundred dollars a month, compared to the original Medicare program. Beneficiaries in fair or poor health save much more, on average, and their coverage is getting even better because

Medicare is concentrating the funds in Medicare Advantage on plans that attract and retain people who have chronic illnesses, where the biggest opportunities for improvements in care are. Medicare now includes a rapidly growing number of special needs plans that offer many extra benefits and reduced out-of-pocket costs for people with chronic diseases and frailty.

These are important steps -- paying more for better care, giving beneficiaries the opportunity to save when they choose a less costly plan that gives them the benefits they need. We're building on this key principle for making Medicare sustainable by developing more ways to measure the quality of care that we're getting and in paying for increasing quality and avoiding unnecessary cost.

That's why, again, with the help of the new Medicare law, we've been developing ways to measure the quality of health care in various settings. One of these is at the Hospital Compare website. It's www.hospitalcompare.hhs.gov, and you can also get there at our Web site, medicare.gov.

Through this program, based on the collaborative Hospital Quality Alliance, a very important partnership, medically valid measures of the care offered by about 98 percent of American hospitals are being made available for heart failure, heart attack and pneumonia. These measures show wide variations in quality, but they also show that hospitals across the board can and will improve quality when that's what they focus on.

And in the next year, we're going to add measures of patient satisfaction and of complications of care.

In another important step towards improving the quality of health care today, I'm pleased to announce the Surgical Care Improvement Project, or SCIP -- a new Medicare partnership.

This project covers measuring and improving surgical care. Here too, the numbers are concerning. They show a lot of opportunity to get more for what we're spending. Among the 42 million operations performed in the United States each year, up to 40 percent have complications afterward. A significant number of these are preventable. Many post-operative infections, for example, can be prevented, but there are wide variations in the use of proven approaches to prevent these complications.

The Surgical Care Improvement Project sets a national goal of using a set of consistent measures to improve post-surgical care to reduce post-surgical complications by 25 percent over the next five years. It involves the American College of Surgeons, the Centers for Disease Control and many other partners. That's the kind of care that we should be paying more to get; better quality care for our patients and overall savings for the Medicare program.

And there's a lot more we're doing to support this kind of care, like helping to develop better evidence on what works for our patients, and helping providers take proven steps to improve quality by using effective health information systems.

If we're able to support doctors and patients just a little better and do it throughout our program, to avoid just a fraction of the ineffective or questionable care and unnecessary costs that go along with it, we can get on-track to make our program financially sound.

For example, we can reduce the deficit in Medicare's 75-year hospital trust fund outlook by two-thirds if we just eliminate 1 percent of the growth in spending, which could be done by addressing inefficient hospital care. If we eliminate just 1 percent in inefficient care in overall Medicare spending growth over the next 5 years, we can improve patient access by increasing payment rates to physicians by 1.5 percent each year, instead of cutting those rates.

Medicare, Medicaid and the State Children's Heath Insurance Program today provide access to care for 80 million Americans. If we don't change the way that we pay -- by paying for quality -- and giving beneficiaries options about how to get better care and lower costs, then all of the $500 billion and growing that we spend may help some people today, but it will reinforce the inefficient aspects of our health care system. Then, our programs and our health care system will fall short. We may have the potential to live longer and better, but we won't be able to afford it if that's the case. And then we'll miss the tremendous opportunities we have in the 21st century for better health.

As we move forward, here's our choice. Paying for health care in the same old inefficient way and falling short, or using new partnerships and paying for what we really want to achieve in the promise of 21st Century prevention-oriented medicine.

If prescription drugs and advances in the detection and treatment of diseases mean that we can prevent illness, or identify it early, and treatment can be increasingly tailored to the needs of individual patients through partnerships rather than broad groups of patients, then why shouldn't Medicare and Medicaid help make that happen?

Medicare and Medicaid are 40. But think about the potential for these programs in 25 more years. At that point, Medicare will be as old as its beneficiaries. I want Medicare to be vibrant and financially secure at that age, just like its beneficiaries should be. Some people think Medicare and Medicaid might be having a mid-life crisis at 40. But I disagree. We do have challenges, but we also have some great opportunities.

I think we'll take advantage of the opportunities to bring the best of modern medical care to our beneficiaries. And if we head in this new direction, Medicare and the people who count on it can have many more healthy years ahead. And I think President Johnson would agree that this is the best kind of dignity: the dignity of a life well-lived, and always getting better.

Thank you all very much for listening to me today.