

GOOD LUCK AND CONGRATULATIONS TO MAJOR GENERAL MORRIS J. BOYD

HON. CHET EDWARDS

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Monday, June 7, 1999

Mr. EDWARDS. Mr. Speaker, I rise to congratulate a great Army officer and soldier—Major General Morris J. “Morrie” Boyd—and thank him for his contributions to the Army and the country.

General Morrie Boyd will retire in June after a long and distinguished career. He is a consummate professional whose performance in over three decades of service, in peace and war, has personified those traits of courage, competency and commitment that our nation has come to expect from its Army officers.

Morrie entered service on the 6th of April 1965. He was selected to attend Officer Candidate School and was commissioned as a second lieutenant in 1966. He served as an artillery officer in Vietnam from October 1966 to June 1968 and again from April 1970 to March 1971. While deployed to Vietnam, he served as an assistant firing platoon leader, executive officer of a battery, commanded a howitzer battery, commanded a platoon from the 21st Aviation Company, and was the Intelligence and Security Officer for the 212th Aviation Battalion.

Morrie was again deployed for combat during Operation Desert Shield/Desert Storm. From December 1990 to May 1991, he served as the commander of the 42nd Field Artillery Brigade in Saudi Arabia.

He came to Washington in the mid-90s to serve as the Chief, Army Legislative Liaison from June 1995 to June 1997. From June 1995 to June 1997, he ably assisted the Army's senior leadership in dealing with Members of Congress and their staffs. He was very focused on helping elected officials and their staffs understand the needs of the Army as it transformed itself from a forward deployed force to a power projection force.

Morrie most recently served as the Deputy Commanding General for III Corps and Fort Hood. Throughout his career, he focused his talent and energy to improve the areas of Warfighting, Training, Modernization, Mobilization, and Quality of Life for soldiers and their families.

On a personal note, I am pleased to call Morrie a close, personal friend. He is a role model for all of us: a man of integrity, decency and compassion.

Let me also say that every accolade to Morrie must also be considered a tribute to his family, his wife of 30 years, Maddie and his son, Ray. As a wife and a mother Maddie has been a true partner in all of his accomplishments.

General Boyd's career has reflected a deep commitment to our nation, which has been characterized by dedicated selfless service, love for soldiers, and a commitment to excellence. I ask Members to join me and offer our heartfelt appreciation for a job well done over the past thirty years and best wishes for continued success, to a great soldier and friend of Congress—General Morris J. Boyd.

INTRODUCTION OF THE MEDICARE PATIENT ACCESS TO TECHNOLOGY ACT OF 1999

HON. JIM RAMSTAD

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Monday, June 7, 1999

Mr. RAMSTAD. Mr. Speaker, new advances in medical technology are improving the lives of millions of Americans every day:

New implantable devices are restoring and repairing ailing organs.

New diagnostics are permitting rapid detection of life-threatening diseases and allowing physicians to peer inside the human body without surgery.

Miniature surgical devices are allowing patients to recover more quickly and new technologies are empowering patients to monitor and test their conditions from home and reduce or eliminate pain.

Yet many of these life-saving and life-enhancing technologies remain unavailable to the people who need them most, America's nearly 40 million Medicare beneficiaries. This is because of the complex, interwoven systems that Medicare uses to evaluate, approve and pay for new medical technologies.

That's why I am introducing “The Medicare Patient Access to Technology Act” to make targeted adjustments in the technical methods and systems that Medicare uses to adopt and pay for new medical products. By correcting and coordinating the payment levels and identification codes, the bill will improve access to needed therapies for millions of Medicare patients, both today and in the future.

As you know, Mr. Speaker, the Food and Drug Administration (FDA) reviews medical technologies to ensure that they are “safe and effective.” After passing through FDA, such technologies must also be deemed “reasonable and necessary” by HCFA for them to be integrated into the portfolio of services that Medicare makes available to its beneficiaries.

After being approved for coverage, technologies must receive a “procedure code,” a four or five digit identifying code that health care providers use in submitting claims to payers.

Finally, Medicare must set a payment level for each technology and treatment through another reimbursement system designed for reimbursing hospitals, physicians, skilled nursing facilities and other care providers.

Unfortunately, a problem at any of these stages can seriously delay a product from reaching Medicare patients.

For example, Mr. Speaker:

Exogen, Inc., a small company that developed an ultrasound device for healing bone fractures, has encountered 4 years of delays in getting Medicare coverage. Oddly enough, the product is currently being reimbursed by more than 800 private insurers and health plans, but not by Medicare.

The Cordis Corporation, a division of Johnson & Johnson, encountered significant problems in obtaining appropriate Medicare coding and payment for coronary stents, which are stainless steel tubes used to treat narrowing of the coronary arteries. The company faced challenges in obtaining a unique code for the stent procedure from HCFA, and once the new code was assigned, Medicare took several more years to place the device in the ap-

propriate payment category. Sadly, the reason for the delay was Medicare's database was only a partial data set and HCFA's precedent did not allow it to use sample data in determining the hospital costs of providing the stent.

A manufacturer of a cochlear ear implant halted active marketing of one model and stopped research on another because of inadequate Medicare reimbursements. According to an article that appeared in *The New England Journal of Medicine* at the time, payment for the device remained well below its average cost, causing hospitals to “ration the availability of the device to Medicare patients because of the financial losses involved. Eventually, so few patients received the implant that the manufacturer discontinued its production.” (Nancy M. Kane, D.B.A., and Paul D. Manoukian, M.D., M.P.H., “The Effect of the Medicare Prospective Payment System on the Adoption of New Technology,” *The New England Journal of Medicine*, November 16, 1989, pp. 1378-1382.)

The most distressing problem in all of these cases, as in many others just like them, is that Medicare patients are being denied access to beneficial therapies.

I am pleased that HCFA is attempting to address the problems associated with its process for making national coverage decisions for new technologies. However, unless the shortcomings in the coding and payment systems are corrected, HCFA will not fully achieve its ultimate goal of improving Medicare's health care delivery system.

Several distinct issues need to be addressed:

Medicare's system for creating and assigning procedure codes to medical technologies is cumbersome and slow.

Medicare's methods of updating Medicare payment levels and payment groups to accommodate changes in medical technology increase the risk that Medicare will lag behind new advances in medical technology.

Medicare's refusal to use data that are developed outside of the Medicare program blinds the program to useful insights about the costs, charges and outcomes of medical technologies.

To address these issues, “The Patient Access to Medical Technology Act of 1999” would:

1. Adjust Medicare payment levels and payment categories at least annually to reflect changes in medical practice and technology.

2. Use valid external sources of information to update payment categories if Medicare's data are limited or not yet available. More specifically, the bill directs HCFA to use a valid, statistically representative sample and also to draw on external sources of data when its own dataset is inadequate. It directs HCFA to consider statistically representative data from such sources as private insurers, manufacturers, suppliers and other non-Medicare entities.

3. Update national procedure codes (HCPCs Level II) more frequently to reduce delays and timelags. Without an accurate identifying code, technologies and procedures cannot be reimbursed appropriately by Medicare. It can take HCFA up to 18 months to approve a new code because of the way the agency structures its calendar for making such changes. This bill would make the process more efficient by eliminating the single annual deadline for applications and permitting such