U.S. SENATE COMMITTEE ON
Finance
SENATOR CHUCK GRASSLEY, OF IOWA - CHAIRMAN
http://finance.senate.gov

**Floor Statement of U.S. Senator Chuck Grassley of Iowa,
Chairman of the Committee on Finance,
and Description of Components of
the Conference Report to Accompany S.1932, the Deficit Reduction Act of 2005
Tuesday, December 20, 2005**

Mr. President, I want to begin by commending Senator Gregg for his tremendous effort in getting us to where we are today on this conference agreement. It's been almost a decade since Congress approved a budget reconciliation bill. I think that's a pretty clear indication of how challenging this process can be. So again, I want to recognize Senator Gregg and all Chairmen of the Committees involved for their commitment over the past several months to achieve this goal. And this goal is such an important one.

Why is it so important? Because by all accounts, the growth in entitlement spending has monumental implications for our nation's economic and financial strength. Take a look at this chart. It shows Congressional Budget Office projections of mandatory spending, including Social Security, Medicare and Medicaid. By 2050, mandatory spending will approach 30 percent of the nation's Gross Domestic Product by 2050. This would push federal spending well above the level that is has been throughout much of the post-World War II period. This is the worst case scenario, but it's a plausible scenario if nothing is done.

The agreement before us begins to get at this situation by achieving nearly $40 billion in savings over the next five years. Given the challenges facing Congress with growing entitlement spending, that’s the equivalent of an elephant giving birth to a mouse. In fact, we really ought to be doing more. The savings under consideration includes $6.4 billion in net Medicare savings and $4.7 billion in net Medicaid savings. Some say any reduction is a bad reduction. But the policy behind the reductions is sound, just as the policy behind the numerous spending provisions in the agreement is sound.

Throughout this process, I have sought to reduce wasteful spending, eliminate loopholes, and pay providers more accurately. I sought to advance policies that will ensure the availability of important health care and social services, to update these programs to reflect our nation's changing needs, and to promote the delivery of high quality health care services.

The agreement makes some important improvements in the Medicare program, not the least of which is addressing a scheduled reduction in payments to physicians, which could have led to access problems for beneficiaries. The agreement builds on progress made three years ago that linked increases in Medicare payments to hospitals to the reporting of quality data.
I actually would have preferred to do more in this area, and I will continue to push for further changes. We just can't sit back on this issue. Medicare is the single largest payer of health care in

the nation. Taxpayers and beneficiaries deserve to get the highest value for every Medicare dollar spent.

Unfortunately, there's no question that today, we just aren't getting the most value. The bill also takes steps to ensure access to quality care in rural communities. It does this by reinstating special payment programs, such as a five percent add-on to rural home health providers, the Medicare dependent hospital program and the hold-harmless payments for small rural hospitals. The conference agreement also includes coverage of valuable preventive benefits not covered by Medicare. These preventative benefits are important to preventing illness and keeping beneficiaries healthy. This bill also saves beneficiaries and Medicare money by changing the payment structure for durable medical equipment. Now Medicare will only pay for DME services that are needed.

In our efforts to reform the Medicaid program, we take some very important steps, many of them recommended with bipartisan support of our nation's governors. Take long-term care, for example. In the very near future, a lot of folks are going to need long-term care. Right now, Medicaid is the primary payer for long-term care services. The Deficit Reduction Act expands the Long-Term Care Partnership Program and will help promote awareness about long-term care insurance. We combine that with a policy to tighten restrictions on seniors' ability to transfer or hide assets with the intention of qualifying for Medicaid. These policies protect the integrity of Medicaid and create an incentive for seniors to explore new long term care options. The agreement will ensure accurate payments to pharmacies for the cost of drugs and it has little effect on the market. We give states the ability to offer Medicaid beneficiaries coverage more consistent with coverage typically offered by employers, while guaranteeing that children do not lose any benefits currently provided under Medicaid. We included protections for preventive services and treatment for children. This bill continues to require states to cover EPSDT, which is Early, Periodic, Screening, Diagnosis and Treatment services. The language of the bill is clear on this point. At this point, I ask unanimous consent to insert a statement by Mark McClellan, Administrator of CMS, supporting our interpretation of the provision. We also include policies that give states the option of asking for a limited set of Medicaid beneficiaries to share in the cost of their care. The cost-sharing policy excludes anyone under the federal poverty level, mandatory children, adoption or foster care children, preventive care and immunizations for all children, pregnancy-related services, hospice residents, and women who qualify for Medicaid under the breast and cervical cancer eligibility group. It is reasonable, responsible policy that I encourage my colleagues to support.

These are important, measured first steps that our governors have asked for on a bipartisan basis to reform the Medicaid program. This bill also dramatically increases funding to protect Medicaid from fraud and abuse. It does this by creating a Medicaid Integrity Program that mirrors a similar program already in place for Medicare.

The agreement incorporates the Family Opportunity Act, which Senator Kennedy and I have worked on for quite some time. These provisions will help families meet the needs of their children with disabilities. Right now, parents of a child with disabilities face difficult decisions. Time and time again, many parents of disabled children tell me of their struggles getting health care for their child. Many parents have been effectively forced to quit their job or take a low paying job so their child can qualify for Medicaid. Why? Because the services their child needs are not available with private health insurance. So they need the assistance from Medicaid. This

policy is totally backwards. The agreement allows states to give parents in this situation the option to buy into Medicaid while continuing to work. These are people who want to work and can work.

The agreement also fills shortfalls in funding for their State Children's Health Insurance Programs that states would have experienced in 2006. It also includes $2 billion to assist Louisiana, Alabama, and Mississippi, as well as other states in meeting the health care needs of people whose lives were devastated by Katrina. It extends TANF programs with a few minor improvements. It closes several loop holes in TANF and in child support, while providing funding for child care, child welfare and allowing more child support money to go directly to families. For nearly four years, I have tried to reauthorize TANF in regular order. Without any help from Democratic members, I reported a bill out of committee in the 108th Congress on a partisan basis. That year, Majority Leader Frist devoted a week for the consideration of welfare. The first floor amendment, offered on behalf of Senator Snowe would have increased child care spending by $6 billion, bringing the total child care spending to $7 billion. It passed with 78 votes. Unfortunately, Democrats blocked the bill. This year I worked on a bipartisan bill that the Committee reported out by voice. But again, efforts to reauthorize welfare in regular order have stalled. If we don't pass the Deficit Reduction Act, we will have to extend TANF for the 12th time. That's absurd. States cannot continue operating their welfare programs unsure of what the next reauthorization will bring. Advocates complain that $1 billion is not enough child care money, but I say to them, where were you for the past year when there was $6 billion on the table? There has never been enough child care money to satisfy those on the far left. $5.5 billion wasn't enough. $7 billion wasn't enough. I don't know if even $20 billion would have been enough. The fact remains that there hasn't been an increase in child care in four years, and if we persist in passing extension after extension, there won't be any new child care funding at all.

Like I said at the beginning of this statement, it's difficult for many to get beyond the numbers. But as I laid out here, this agreement includes many provisions to provide services that better meet people's needs and it does so by getting rid of waste and abuse in the programs. These are dollars that right now we are simply throwing away. They get taxpayers and beneficiaries nothing. Without some changes, these important programs, Medicare, Medicaid, TANF, will be driven into the ground. That some don't support these changes, well, to me, it seems they can't see the forest for the trees. The agreement before us includes sound policies. It achieves savings by reducing wasteful spending, closing loopholes, and taking steps to pay providers more accurately. It improves oversight of Medicaid to crack down on fraud and wasteful spending. It establishes policies to help families and beneficiaries and to ensure the long-term viability of these programs. I urge my colleagues to support the agreement.

Description of Components of the Conference Report to Accompany S.1932, The Deficit Reduction Act of 2005

Screening for Abdominal Aortic Aneurysms (AAA)

This provision provides coverage for ultrasound screening for Abdominal Aortic Aneurysms (AAA) under the Welcome to Medicare initial physical. These provisions along with other provisions in the bill support the need for prevention. Individuals eligible for the screening are those who are at high risk or have a family history of AAA. The Part B deductible would not

apply. Making these screening tests more accessible and affordable is a key factor in influencing seniors to get screened. Excluding this screenings from the Part B deductible is consistent with the policy for other screening tests currently covered under the Medicare physical. The U.S. Preventative Services Task Force (UPSTF) reports that abdominal ultrasounds for AAA are 95 percent sensitive and nearly 100 percent specific. This provision ensures that those Medicare beneficiaries at high risk will receive this important screening.

Aligning Payments in Ambulatory Surgical Centers (ASC)

This provision ensures that payment rates for services delivered in an ambulatory surgical center do not exceed payment rates for the same service provided in a hospital outpatient department. Payments for the same procedure should be paid at the same price, even if they are provided in different settings. MedPAC has said that differences in payment may result in financial incentives that shift the site of service to the most profitable setting. This leads to increased costs to the Medicare program and its beneficiaries. In its March 2004 report MedPAC studied ambulatory surgical centers (ASCs). They found that in 2004, payments in ASCs exceeded the hospital outpatient payment rate for 13 percent of procedures. However, there does not appear to be any evidence that suggests ASC costs are higher than outpatient department costs. MedPAC has recommended that the Secretary revise the ASC payment system so that payments are aligned with the hospital outpatient prospective payment system. MedPAC recommends that Congress ensure that payment rates for ASC procedures do not exceed hospital outpatient payment rates for the same procedure. There should be no difference across sites of service for the exact same procedure.

Asset Transfers

Our current asset transfer policy is flawed. The policy not only allows for exploitation, it encourages it. The current statute has loopholes that allow seniors with significant wealth to qualify for Medicaid. An entire industry has developed to assist seniors in crafty estate planning. This industry helps wealthy seniors qualify for Medicaid by using schemes to shield their assets. Medicaid is not an inheritance protection program. Medicaid exists to protect the most vulnerable people. We need a fair, equitable policy. We need to protect the Medicaid program for those who need it most. This bill fixes the problem by closing the loopholes in current Medicaid law. First, the new policy prevents seniors from intentionally shielding their assets in annuities and special accounting gimmicks. Seniors should not be able to hide their money to qualify for the Medicaid program. Second, the new policy changes the look-back period as well as the penalty period clock. Right now, a senior can shelter half their assets the day before they apply for Medicaid. The new policy starts the penalty period when the senior applies for Medicaid, and the look-back period is lengthened from three years to five years. Now, a senior will face a penalty if they transfer assets for the purposes of qualifying for Medicaid within five years of applying for Medicaid. This puts teeth in the asset transfer policy. The new policy doesn't allow an individual with more than $500,000 in home equity to be able to qualify for Medicaid. It does provide state flexibility to increase the cap to $750,000. This is sound policy. Those with home equity over $500,000 should not take Medicaid money from those whom the Medicaid program was designed for: low-income children, pregnant women and individuals with disabilities. Also, the policy only applies to individuals. It does not apply to applicants who have a spouse or a dependent child at home. In theory, the state is supposed to be able to put a lien on that home anyway. Finally, seniors who have a hardship can apply for a waiver. The policy strengthens protections for seniors seeking an undue hardship waiver beyond current law or the Senate passed version. This provision doesn’t make it harder for those people who really

need the government's help. It does attempt to prevent intentional attempts to take advantage of the system and protect Medicaid for those who need it most.

Beneficiary Ownership of Certain Durable Medical Equipment

This provision transfers ownership of DME, such as walkers, wheelchairs and hospital beds to the beneficiary after the 13th month. By allowing beneficiaries to own DME it saves the Medicare program and its beneficiaries a significant amount of money. The Medicare program currently pays 120 percent of the purchase price over 15 months. This provision makes payments more appropriate. By changing the transfer date to the 13th month, it lowers the amount Medicare pays to 105 percent of the purchase price. Medicare also provides maintenance and servicing fees every six months, whether servicing is provided or not. A six-month study done by the OIG in 2000 found that only nine percent of DME actually received any maintenance and servicing. Under current law, beneficiaries pay 20 percent of the six-month maintenance fee. This provision reduces a beneficiary's out-of-pocket costs by holding them responsible for 20 percent of repairs and servicing only when servicing and repairs are provided. For repairs requested, Medicare will pay hourly for labor and separately for parts, as well as pay for loaner equipment until the item is repaired. Beneficiaries will still have the option to purchase a power wheelchair in the first month. It is time Congress questioned the appropriateness of the current DME payment structure. The federal government has a fiscal responsibility to both Medicare beneficiaries and its taxpayers. For these reasons I urge my colleagues to support this provision.

Beneficiary Ownership of Oxygen Equipment

This provision transfers ownership of oxygen equipment to the beneficiary after 36 months. Beneficiaries will now have more control over their oxygen needs, by allowing them to purchase after 36 months. However, this provision also ensures that all beneficiaries who rely on oxygen are covered. Medicare currently pays around $200 a month for renting oxygen equipment. On average Medicare beneficiaries use oxygen for 30 months, which means Medicare pays $6,000 for a beneficiary. If a beneficiary needs oxygen for longer than 30 months this provision allows the beneficiary to rent for another six months. After 36 months, the beneficiary still receives monthly payments if they use a portable system that requires the delivery of oxygen. And if maintenance and servicing are required, then Medicare will cover repairs and servicing as needed. However, the beneficiary is given more control to determine when servicing is necessary. Congress needs to move towards a better payment system that protects our beneficiaries and the integrity of our Medicare program. This is a good first step.

Citizenship ID Provision

Under current law, states are required to verify that people are legally eligible to receive Medicaid benefits. One of those requirements is that you be a citizen or a qualified alien. An Inspector General's report this summer showed that 47 states allow applicants to self-attest their citizenship. An applicant needs to only answer the question by saying, "Yes, I am a citizen." The report further showed that 27 states do not follow up in any way to confirm that statement. The policy requires states to get specific documents from applicants to establish their citizenship. It's the law and we simply are asking states to do a better job of following it.

Colorectal Cancer Screening

This provision exempts colorectal cancer screening tests from the Part B deductible. This is an important step in providing needed preventative benefits for beneficiaries. Colorectal cancer is the second leading killer in the US, yet the majority of high risk individuals have not

been screened as recommended by the national guidelines. Making these screening tests more accessible and affordable is a key factor in influencing seniors to get screened. Excluding this screening from the Part B deductible, is one step towards this goal. According to the Centers for Disease Control, screening for colorectal cancer lags far behind screening for breast and cervical cancers, which are also exempt from the Part B deductible. This provision puts screening for colorectal cancer on the same level as other preventative screenings. By making prevention more affordable, Medicare beneficiaries will be encouraged to utilize this important life-saving screening.

Cost-Sharing Enforceability

Some argue that by allowing providers to enforce cost-sharing we are hurting beneficiaries. That characterization is incorrect. Under current law states can require cost-sharing but it is not enforceable. Simply put, providers have a Hobson's choice. If a beneficiary refuses to pay, the provider is forced to absorb the co-pay. The provider's only option to avoid this problem is to not participate in Medicaid. And we know that many providers simply choose not to participate in Medicaid. This all or nothing approach hurts beneficiaries by driving providers from the program. This provision gives providers a third choice. They can come back to the Medicaid program and provide access to beneficiaries. The provision gives them the ability to make case-by-case decisions on enforceability. This will likely increase provider availability to beneficiaries rather than decrease it. This is reasonable responsible policy supported by the Governors..

Cost-Sharing

The conference report includes reasonable policy that allows states to ask beneficiaries over the poverty line to participate in the cost of their own care. The House bill allowed states to require cost-sharing for beneficiaries with no income. That is wrong policy, and the Senate demanded that be struck in conference. A beneficiary who is above the poverty line can be asked to pay up to five percent of their monthly income to the cost of their care, and that is only if the state chooses to impose additional cost-sharing. No state is required to do this. Some may argue that Medicaid should never require beneficiaries to pay for anything. The National Governors Association does not support that position. They support reasonable responsible cost-sharing. We've created such a policy in this conference report.

End Stage Renal Disease

This provision provides a 1.6 percent update to the composite rate for End Stage Renal Disease (ESRD) services in 2006. An update that's needed to cover the growing number of ESRD patients in the U.S. Currently, ESRD facilities do not have a permanent update to the composite rate. In 2005, the Medicare Modernization Act (MMA) provided a composite rate update of 1.6 percent. A drug add-on to the composite rate was also provided. Between 1993 and 2002, the number of ESRD patients grew by about 6.3 percent per year. This growth is linked to the aging of the population as well as an increase in the number of people who suffer from diabetes. Due to this increase in growth, total Medicare spending for ESRD services increased by 10 percent each year between 1996 and 2003. An extension of the composite rate update for another year is important as we continue working towards implementing provisions of the MMA. This update will ensure that payments will be sufficient to provide high quality dialysis services to those in need. For the future, updates should be provided based on the quality of care ESRD facilities provide.

Federally Qualified Health Centers

This provision expands Medicare reimbursement for services at federally qualified health centers (FQHC). This provision is needed to ensure that these health centers can provide care where care is needed but scarce. Under current law, FQHCs are reimbursed for services through an all-inclusive rate under Part B of Medicare. This provision allows FQHCs to provide diabetes self-management training services and medical nutrition therapy services which are currently not included under the all-inclusive rate. Additionally, the provision allows FQHCs to receive payments for services provided through a health care professional who contracts with the center. This allows additional providers to participate in providing care in the areas that desperately need assistance. Finally, this provision removes restrictions on receipt of homeless grants. All these provisions expand access to care in community health centers.

Gainsharing Demonstration

This bill includes a three-year voluntary demonstration that evaluates gainsharing arrangements between hospitals and physicians. This demonstration will help the Medicare program move toward a more coordinated health care delivery system that improves quality of care and saves money. In my opinion, the term gainsharing should actually be referred to as quality sharing because quality is the primary factor that will drive efficiency and cost savings. Instead of allowing current law to stifle innovation, this demonstration will allow us to take a closer look at what these quality sharing programs have to offer. This demonstration is critical for two reasons. First, physicians are the ones who can actually control costs because they know where waste is occurring. Second, the whole purpose of quality sharing is that it targets the waste of resources in order to improve quality. The demonstration will have a total of six sites with two sites located in rural areas. This demonstration is one small step toward rewarding providers for working together to improve care. Participants of the demonstration will be required to maintain or improve quality while achieving cost savings. Currently, the Medicare program pays each provider group under a different payment system. Each provider group is broken up into different silos and each has a different payment system. Even when hospitals wanted to work with physicians they were unable to provide any incentives. This demonstration will help the Medicare program move toward a more coordinated health care delivery system that improves quality of care and saves money.

Hold Harmless Payments for Small Rural Hospitals

This provision provides a three-year transition for hold harmless payments as Congress looks for a more permanent solution. These payments are critical for rural hospitals so that the transition to a new payment system does not hurt them. Payments will continue to be provided so that small rural hospitals that are dependent on these additional payments can still receive them. However, rural sole community hospitals do not need these transitional payments. CMS has already included a 7.1 percent increase in their payments for 2006. For that reason, this provision does not include rural sole community hospitals. Small rural hospitals have a hard time because they provide more basic services that require fewer resource, making their payments lower than those of urban hospitals. MedPAC has recommended a low-volume adjuster, however in order to get this right we need more time. Several years of data is needed to avoid problems of variation in volume. For these reasons we provide 95 percent of the difference between the prior payment system and the hospital outpatient payment system in 2006. In 2007 we provide 90 percent of the difference and in 2008 we provide 85 percent of the difference. This will allow Congress more time to come up with a solution that works.

Payment for Home Health Services

This bill makes needed reforms to home health payments. These reforms will reduce disparities in provider payment, improve quality and transparency, and save the taxpayers' money. First, the bill calls for a one-year 5 percent add-on payment for home health agencies that serve rural beneficiaries. This is good policy. Medicare margins for rural home health agencies are consistently lower than those of urban home health agencies. This reconciliation bill will take steps to lessen that difference. Second, the bill calls for home health agencies to report quality data in 2007. Currently, home health payments do not distinguish between high-quality and low- quality providers. Including a financial incentive for home health agencies to improve care will reward those that are committed to quality improvement. This information will be made available to the public so that individuals can make informed decisions about their health care. This policy was recommended by the Medicare Payment Advisory Commission (MedPAC) in March. And, is similar to the hospital quality initiative that Congress adopted for hospitals in 2003. Third, the bill calls for a freeze in the home health payment rate for 2006. Medicare is currently paying home health agencies approximately 17 percent more than it costs agencies to provide home health services. This freeze was also recommended by MedPAC in its March report to Congress.

Aligning Payments for Imaging Services

This provision addresses the increase in physician office imaging by aligning physician payments with hospital outpatient department payments. This does not decrease payments to hospital outpatient departments. As a response to proposed payment cuts physicians have increased the number of services they perform. By making payment for imaging services more appropriate, Congress can use the savings to help alleviate the physician payment problem. MedPAC found that Medicare spending for imaging services paid to physicians increased by over 60 percent from 1999 to 2003. During the same time, imaging services grew at a rate twice as high as other physician services. Research suggests that additional services do not always equate to better quality. Because Medicare uses different payment methods for imaging services in different settings, many services are often paid more when performed in a physician's office. This bill ensures that payment rates for imaging services delivered in a physician's office are not higher than the same service provided in a hospital outpatient department. For example, for an MRI of the brain, a hospital outpatient department receives $506 and for the same procedure a physician's office receives $902. Large differences in payments create an un-level playing field, which provides an incentive to furnish an imaging service in one setting over another. This additionally provides an incentive to over-utilize services, which increases beneficiary cost-sharing amounts and the Part B premium. The government should move towards payment neutrality across sites of service. MedPAC also recommended in its March 2005 report that Medicare pay more accurately for multiple imaging services performed during the same visit. CMS is working to implement a policy that pays a discounted rate for multiple imaging tests. This bill achieves savings from these reductions in 2006 and 2007. These savings are returned to the Medicare program rather than put back into the pool for physician payments. Physicians have a flawed formula that leads to cuts in payments. Physicians responded by increasing the number of services. This has increased Part B expenses, making the problem more expensive to fix. In order to address this problem Congress did two things. The first is a freeze in 2006 and the second is paying appropriately for the services provided.

Medicaid in Brief

The Medicaid policy in the conference report is reasonable, responsible policy. It

replaces the obviously broken AWP system with a new payment formula for pharmacists that minimizes disruption and allows states to set payment rates based on full information. It closes loopholes that allow seniors to intentionally transfer assets to get on Medicaid while expanding opportunities for seniors get coverage through Long Term Care Partnerships. It allows states to require beneficiaries to share in the cost of their care but places responsible limits on how much can be asked of a beneficiary. It allows states to enroll healthy Medicaid beneficiaries in a benchmark coverage plan, like a state employee plan but guarantees that no child loses any Medicaid benefits. These are all provisions suggested by and supported by our nations' governors as critical to strengthening and protecting the Medicaid program.

Medicare Disproportionate Share Hospital Calculation

This provision codifies current administration policy on disproportionate share hospital payments. The legislation does not change the current formula used to calculate DSH payments. It expressly ratifies the administration's policy to include 1115 waiver days in the DSH formula. Simply put, the Centers for Medicare and Medicaid Services (CMS) established a DSH policy back in 2000 and said the policy would be applied prospectively. It allowed for certain patients receiving medical assistance under Section 1115 expansion waiver demonstration programs to count toward the calculation of DSH payments. In 2003, CMS reiterated and clarified this policy. The problem is that two district court decisions are claiming that CMS' 2000 policy can be applied retroactively as well as prospectively. The language used in these cases questions the validity of CMS's second, clarifying, policy. Congress agrees with the administration's 2000 policy and with its prospective application. This bill codifies in statute the administration's policy on the calculation of disproportionate share hospital payments. In fact, it prohibits the administration from making changes or revoking its 2000 policy which includes these populations in the DSH calculation. This is in the best interest for both hospitals and the populations serviced under Section 1115 expansion waiver demonstration programs.

Part B Income Related Premium

This provision accelerates the phase in of the increased premium for higher income Medicare beneficiaries. The Medicare Modernization Act (MMA) increased the Part B premium for higher income enrollees starting in 2007. The conference report does not changing the amount, just the time line. This provision accelerates the phase-in from five years to three years. Under the MMA, individuals with incomes over $80,000 and couples with incomes over $160,000 are subject to higher premiums. When fully phased in, the higher income individuals would pay total premiums ranging from 35 percent to 80 percent of total Part B costs. Based on the MMA language, the Congressional Budget Office (CBO) estimates that three percent of beneficiaries will pay higher premiums in 2007 and six percent of beneficiaries will pay higher premiums in 2013. This provision does not change the percentage of Part B costs paid by beneficiaries. It only accelerates the time line.

Part B Penalty Waiver for International Volunteers

This provision will allow overseas volunteers of 501(c) (3) organizations to waive their Part B premiums. International volunteers should not have to pay double for health insurance coverage. There are several older Americans that volunteer overseas and dedicate their time and resources towards various causes. During this time, these volunteers pay 100 percent of their expenses except for transportation to and from their country of service. The Medicare program does not cover volunteers while they are outside the United States. If beneficiaries want health care while abroad, they are required to purchase other insurance that provides international health

benefits. These volunteers are still required to pay Medicare Part B premiums in order to avoid future penalties when they return to the States. These volunteers end up paying for two medical plans even though they are not receiving any benefits from Medicare. This is unfair. I have included a provision to allow volunteers of 501(c)(3) organizations to waive their Part B penalty, if they show proof of insurance while abroad. Having to pay Medicare premiums as well as other health care premiums while volunteering should not discourage individuals from volunteering abroad. We should encourage overseas volunteerism as much as possible. This provision supports those seniors who give so much of themselves to help others. I encourage my colleagues to support this provision and this bill.

New Pharmacy Policy

Medicaid pays more for drugs than any other purchaser. CBO has shown this. GAO has shown this. This is bad policy. The Medicaid program should use its resources wisely; after all, we are taking care of the most vulnerable people. It is time for a change. Our main concern is that we have appropriate pharmacy payment. The Medicaid program currently overpays pharmacists by billions of dollars. Right now, the amount that pharmacists are paid by Medicaid is not an accurate reflection of what drugs cost. In fact, a recent OIG study showed that pharmacists make a 70 percent markup when they dispense a generic drug to a Medicaid beneficiary. This is not right. It is not right for the Medicaid program, and it is not right for the taxpayer. The new pharmacy payment policy changes this. The policy ensures that states know the actual price the pharmacist pays for the drug. Then states can pay pharmacists fairly. For brand name drugs, we leave current law as is. States can use the new information we provide them to determine what price they think is right. For generic drugs, the policy establishes a new federal upper limit. Pharmacists will now be reimbursed at 250 percent of the lowest price of the generic drug. Not 15 percent or 20 percent more than some price, but 250 percent. By using the Average Manufacturer Price, or AMP, we are now using a more accurate method of determining the cost of pharmaceuticals through a price that is reported and auditable. This is a good policy. It protects small purchasers who pay more than the average price for drugs and also drives generic utilization. Because the price of the brand drug is typically greater than the generics, this creates an incentive to dispense the cheaper generic drug. You may have heard that pharmacists are being hit too hard, BUT, this policy is paying 250 percent above the lowest price in the market. Most importantly, states will have access to A-M-P pricing data for drugs. The AMP data will be updated monthly and be publicly available on a website. This pricing transparency will ensure that states are paying appropriately for drugs by affecting market competition. In addition, the Secretary may contract with a vendor to determine retail survey prices (RSP) for prescription drugs. This will further ensure that pharmacies are being reimbursed fairly. This bill also requires states to annually report their pharmacy payment rates, dispensing fees, and utilization data on generic drugs to the Secretary. This will also enhance competition and ensure that pharmacies are being paid fairly. This is an appropriate and responsible policy that is in the best interest of the Medicaid program and the taxpayer and I encourage my colleagues to support it.

Update Payments for Physician Services

This provision prevents physician payment cuts in 2006 by providing a freeze in payment rates for physician services. Physicians are scheduled to receive a negative 4.4 percent cut on January 1, 2006. Physicians are estimated to continue to receive negative cuts of approximately five percent from 2006 to 2011. These cuts are due to a flawed SGR formula. A flawed formula that has resulted in a steady increase in the number of physician services provided. A concern

that the formula has tried to address. Congress needs a long term solution. However in the short term it is important to prevent cuts in order to maintain access. Congress and the Administration also need to continue working towards replacing the SGR formula. This bill includes a MedPAC study that will recommend alternatives to replace this flawed formula. It will also be important to move physicians towards a value-based payment system. A value-based purchasing system will achieve better health outcomes through higher quality and more efficient care. Until this change occurs, it is important to prevent the cut until physicians start working on developing a value-based purchasing system. In 2006, the voluntary reporting of quality measures will provide valuable insight as to how to develop a long term mechanism to control utilization yet reward high quality care and better health outcomes.