Statement of Senator Tom Coburn, M.D.
May 22, 2008

Politicians can’t keep their entitlement promises.

Medicare and Medicaid cost the American taxpayers a combined $770 billion in 2007; Medicare costing $432 billion and Medicaid $338 billion.

In 2007, the federal government’s share of Medicaid expenditures was $190 billion and is expected to be $402 billion by 2017.

Medicare expenditures alone account for 3.2 percent of GDP. Over the next 75 years these expenditures are expected to explode to almost 11 percent of GDP. Every American household’s share of Medicare's unfunded obligation is like a $320,000 IOU.

The Medicaid program, because of the promise of a generous federal match of state Medicaid dollars, has given states heavy incentive to increase their state Medicaid spending. Medicaid spending now accounts for 26.3% of state budgets, up from just 6.7% in 1970. In some states, as much as half of all new revenues will go to Medicaid in the coming years.

We’ve heard a lot of talk about Bi-Partisan Commissions on entitlement reform come out of the Budget Committee, but the least that we can do is to stop blatant fraud and abuse in the mean time.

Eliminating waste, fraud, and abuse is a baby step in addressing entitlements.

The Centers for Medicare and Medicaid Services (CMS) has worked over the last 5 or so years to curb waste, fraud, and abuse. They have done work on a state-specific basis and also by promulgating detailed regulations so that states have the clarity they need.

Over the years, Medicaid has proven to be a program susceptible to fraud, waste, and abuse. Many states have pushed the limits of what should be allowed to maximize the federal dollars sent to them.
The Government Accountability Office (GAO) put Medicaid on its “high risk” report a few years back because of questionable financing and the lack of accountability.

According to the Wall Street Journal, “The GAO and other federal inspectors have copiously documented these “creative financing schemes” going back to the Clinton Administration. New York deposited its proceeds in a Medicaid account, recycling federal dollars to decrease its overall contribution. So did Michigan. States like Wisconsin and Pennsylvania fattened their political priorities. Oregon funded K-12 education during a budget shortfall.”

According to the Wall Street Journal, “The right word for this is fraud. A corporation caught in this kind of self-dealing – faking payments to extract billions, then laundering the money – would be indicted. In fact, a new industry of contingency-fee consultants has sprung up to help states find and exploit the "ambiguities" in Medicaid's regulatory wasteland. All the feds can do is notice loopholes when they get too expensive and close them, whereupon the cycle starts over. ... No one really knows how much the state grifters have already grabbed, though the Congressional Budget Office estimates that the Administration remedies would save $17.8 billion over five years and $42.2 billion over 10. We realize this is considered a mere gratuity in Washington, but Medicaid's money laundering is further evidence that Congress isn't serious about spending discipline.”

Examples of fraud in the Medicaid program are plentiful. One dentist billed Medicaid 991 procedures in a single day.

According to the New York Times, a former state investigator of Medicaid abuse estimated that as much as 40% ($18 billion) of New York’s Medicaid budget was inappropriate.

New York spent $300 million of its Medicaid money on transportation.

In 2005, Congressional testimony showed that 34 states hired contingency-fee consultants to game federal Medicaid payments.
Medicaid regulations by CMS are efforts to provide clear guidance in critical areas where there have been well-documented problems and result from years of work on the part of CMS and myriad reports by the GAO and the Office of the Inspector General (OIG) at the Department of Health and Human Services (HHS).

When CMS doesn’t know how a state is billing for a service and states don’t have clear guidance for how they should, neither Medicaid beneficiaries nor the taxpayers are well served. The Medicaid regulations fix that problem.

According to the Congressional Budget Office (CBO), the regulations would save the Medicaid program $17.8 billion over five years and $42.2 billion over 10 years by eliminating wasteful and fraudulent federal payments to the program.

The federal government will spend $1.2 trillion over the next five years on Medicaid, so the regulations save only about 1 percent of federal spending on Medicaid. If Congress is afraid of taking on these very modest changes to Medicaid, does it really have the will to take on the special interests that is necessary to truly address entitlement reform?

The very purpose of these regulations is to build accountability into the Medicaid program that is long overdue.

**The proposed delay is a budgetary gimmick to avoid paying for the real costs of delaying the Medicaid regulations.**

CBO estimates that delaying the rules until April 1, 2009 would cost $1.65 billion. However, if the rules were withdrawn or permanently delayed—as it’s likely they would be under the next Administration—the CBO estimates a 5-year year cost of $17.8 billion and a 10-year cost of $42.2 billion.

**Even if the regulations should be delayed, a war supplemental is the wrong place to include Medicaid policy changes.**

The war supplemental is given expedited consideration procedures because funding our troops is an urgent matter. The Medicaid regulations have been considered for years,
and Congress has already put one 6-month delay on them. This isn’t a new or urgent issue that justifies inclusion in a war supplemental.

If ensuring that America’s safety net programs are adequately funded is such an important issue, it deserves the full debate and consideration of the Senate. Burying a flat-out moratorium of Medicaid regulations on a war supplemental appropriations bill isn’t being honest with the American people.

Congressional leaders put a moratorium on the Medicaid regulations last year and are poised to do so again. If Congress truly opposes the regulations, then it should repeal them instead of pretending to “study them” a little longer. However, Congress is avoiding that kind of honesty because it will cost ten times the amount of a moratorium.

**Instead of blaming the Bush Administration, Congress needs to decide for itself how it will address waste, fraud, and abuse in the Medicaid program.**

The Bush Administration has taken its turn and taken a stand to protect the integrity of one of our largest entitlement programs. Now it is Congress’ turn.

This is no longer about the Bush Administration. This is now about Congress. Congress needs to decide whether or not it will ignore years of GAO and HHS OIG reports. Congress needs to decide whether it will listen to their state Medicaid directors and governors or whether it will safeguard taxpayer dollars.

States have had their turn and demonstrated that they will take advantage of loopholes, ambiguities, and lack of clarity. Congress is the one ultimately responsible for these programs. Congress is elected to set policy and fund priorities.

By imposing another moratorium, Congress is failing to live up to its responsibilities. Congress is running away from them. Congress has closed its eyes and ears to the abuses that have been going on. By stopping the regulations from going into effect, Congress is simply giving more sugar to a diabetic. It may feel good for a moment, but it is not good in the long run.
Congress doesn’t really need another year to deal with these issues. These abuses have been going on for a long time. The GAO and the OIG have been issuing audits and reports on the abuses for years.

**Problems with the regulations themselves warrant a conversation not a moratorium.**

There have been very few substantive policy disagreements with the Administration’s regulations. The Finance Committee hasn’t engaged the Administration on specific problems with the regulations. There have been no hearings over the last 6-month delay. The only “hearing” that has occurred is the parade of Governors and providers pleading to not turn off the funding.

**The rule to impose a cost limit on government providers (CMS-2258) is common-sense and good government.**

The cost rule saves $9 billion over five years and $22 billion over 10 years by ending creative state financing schemes.

First, it requires that providers, like hospitals and nursing homes and physicians, receive and retain the total computable amount of their Medicaid payments for the services they provided. Why would Congress object to that? It seems simple that if you provided a service, you should get to keep the money.

During the 1990s, states figured out creative ways to pass off their obligations to providers. That was wrong and unfair. Each time Congress stopped one financing practice, a new financing scheme popped up.

In 1991, Congress cracked down on loopholes in provider taxes. States opened up new loopholes. In 1997, Congress cracked down on abuses in the Disproportionate Share Hospital (DSH) payments program. In 2000, it tried to stop the abuses in Upper Payment Limits, though it failed to close them completely.

In 2003, the Bush Administration put new emphasis on ending these schemes through the state plan amendment review process. This strategy proved to be effective and many states ended their “recycling” arrangements. But some states complained to Congress.
In July 2004, Senator Baucus wrote the Administrator of CMS: “As you know, and as I indicated to you in those conversations, I feel strongly that any new CMS policy on intergovernmental transfers (IGTs) must be implemented in a manner that is transparent, that is applied equally to all states, and that responsibility takes into account the potentially serious financial consequences of eliminating a source of state funding on which some states have a longstanding reliance. Based on my understanding of current law and practice, with respect to IGTs, and on my interest in promoting public confidence in government decision-making judgment that a rulemaking or legislative process is warranted in these circumstances. Accordingly, I urge you to develop rules or a legislative proposal as soon as possible on this issue.”

The current Chairman of the Finance Committee requested Medicaid regulations nearly 4 years ago. The Administration has responded to that request by promulgating regulations.

As soon as the regulations left the desk of the CMS Administrator, Congress blocked them from going into effect last year.

What has Congress done since then in the way of hearings or conversations with CMS? Nothing. What is Congress doing now? Trying to delay them again.

Chairman Baucus is right about treating states equally; Congress needs to let CMS do so.

It is ironic that hospitals are telling Members to stop the Medicaid rules. The policy of the cost rule is that providers should get to keep the full amount of Medicaid reimbursement paid for the services they deliver. Why should hospitals or other types of providers be forced to send part of their payment for services back to the state or local government? It is not their responsibility to fund the state’s share of the cost of Medicaid. That is the responsibility of the state and local governments.

Another major part of the cost rule seeks to limit government providers to cost. This has been a recommendation of GAO dating back to 1994. Under this provision, government providers would receive 100 percent
of their costs for delivering services to a Medicaid recipient. But they would be limited to cost, they simply could not charge a “profit” to the federal taxpayers.

A government entity shouldn’t bill the taxpayer for more than the cost of delivering a service. That is nothing more than Medicaid subsidizing non-Medicaid activities. If state and local officials decide not to fund a program, that doesn’t mean the federal taxpayer should pick up the tab.

Congress may have heard pressure from their states about how the cost rule will “shred the safety net.” If Congress really cared about hospitals, shouldn’t Congress be supporting the policy that they get paid in full? When this type of policy was put in place in California, revenues to hospitals increased by 12 percent.

If Congress really cared about providers, there are other tax-relief policies Congress that would be helpful to them. Provider taxes on hospitals, nursing homes, and others totaled $12 billion in 2007.

The estimated savings for the cost rule for 2008 and part of 2009 is about $770 million. If you accept the argument that all providers in the entire country will “lose” $770 million if the cost rule goes into effect, consider that the hospitals in New York alone paid $2 billion in provider taxes. The hospitals in Illinois paid $747 million in provider taxes. If Congress really cared about them, what about a little tax relief instead?

The real story is that states are using creative “provider taxes” to forego paying their share of the Medicaid program. A few years back, Congress gave a special deal to Illinois supposedly to support the Cook County Hospital system worth about $350 million per year. The hospital is forfeiting more than $300 million in order to generate supplemental payments back to the state for this.

If you add provider taxes and what Cook County hospital is forfeiting, it totals a billion dollars per year impact on hospitals in Illinois. Instead of addressing that blatant example of taxpayer money abuse, these rules are an easier target.
Senator Baucus is right that the states should be treated equally. The Senate should instruct the Finance Committee to identify all of the special treatment situations and report legislation to get rid of them.

The school-based administrative costs and transportation rule (CMS-2287) ensures that Medicaid money goes for medical care—not school buses.

First, those individuals and groups who have been scaring parents of a child with a disability that this rule will end their child’s treatment need to hear the truth about what this rule does. Schools are required to provide such services and if a child is on Medicaid, Medicaid will continue to pay for medically necessary services.

This rule ensures that Medicaid pays only for medical and medically necessary services. Medicaid administrative claiming among schools varies widely among states. There are many states that do not bill Medicaid for administrative activities at all. Much of the funding is concentrated in a small group of states.

Abuses in administrative claiming have been well documented. Comments on the rule confirm that schools are simply using Medicaid as a source of revenue to support activities that are related to education, not health care.

Medicaid reimbursement has been used for a wide variety of unrelated purposes such as instructional materials and equipment or to fund staff positions. Schools use funds to attend workshops and purchase educational technology and materials, even to support after school activities, arts and music programs.

There is no problem with those types of programs, but there is a problem when Medicaid is paying for them. If citizens at the local level decline to raise their property taxes for education, that doesn’t mean that federal taxpayers should have to pick up the tab. If state legislators increase funding for transportation rather than education, Medicaid shouldn’t be the means of easing the impact of their decision.

Allowing schools access to open-ended funding of Medicaid with virtually no accountability will erode the decision-
Another rule (CMS-2279) would stop the use of Medicaid dollars—intended for low-income people—going to fund training for doctors.

There is no question that training the next generation of physicians in this country is important. However, it should be paid for out in the open. There needs to be accountability as to where the dollars go and for whom they are used.

Under Medicaid’s Graduate Medical Education (GME) funding, there is no obligation on the part of physicians who are trained with Medicaid dollars to serve Medicaid patients once they graduate. In contrast both the military and the public health service corps require time commitments as repayments for help with medical school.

There is no authority in the Medicaid statute to pay for GME. It is not there. Congress and CMS don’t even know the exact fiscal impact of this rule because states are not required to report expenditures as GME.

If Congress wants to fund a training program for doctors serving poor people, it should be done out in the open with real program accountability.

I understand concerns that CMS shouldn’t just abruptly end the Medicaid GME program without a transition plan in place, but at the same time the Administration is right in questioning how this money is spent. If we’re going to fund residency training, we should do it right and out in the open.

The Targeted Case Management (CMS-2237) rule targets scarce Medicaid dollars.

In the Deficit Reduction Act of 2005, Congress appropriately acted to end state abuses. The rule promulgated by CMS is designed to be person-centered, comprehensive, and demand accountability.

CMS has been accused of overstepping its authority because it is applying the criteria across the board however case management is delivered. It other words, states cannot get
around the rules by hiding under administrative claiming rather than actual services. And that applies to home and community based service waivers as well as state plan amendments. So the complaint is really this—CMS did not leave any loopholes open.

There are generally 3 provisions that have drawn the most complaints about this rule.

First, **there is a complaint about charging Medicaid only for a single case manager.** The message of this requirement is simple and sensible—if you are the case manager for a person with mental illness, you should be capable and qualified to deal with all sorts of issues like housing and employment as well as health care needs. Why should Medicaid pay for 4 or 5 different case managers? Case management by qualified professionals should lead to better outcomes for the individual and lower costs in the long run.

If one case manager is too few, then let the Finance Committee figure out if it should be 2 or 3 or 4. We don’t need a one-year moratorium to figure that out.

This provision does not take affect for another year—without the moratorium—so there is no immediate impact on states. They have plenty of time to come into compliance.

The second complaint is based on another accountability provision—billing in 15 minute increments. This will help ensure that rates are appropriately set and that there is an audit trail.

If 15 minutes isn’t appropriate, then we can change the time allotment. We don’t need an all-out moratorium on the rule to figure that out.

The third common complaint is about limiting the period of time for which case managers can bill for transitioning an individual from an institution into the community. The rule provides that the transition period is the last 60 days of an institutional stay that is 180 days or longer.

If 60 days is too short, then let us have the Finance Committee tell us what the right number is.
The targeted case management rule was published December 4, 2007, nearly 6 months ago. That certainly is plenty of time for the Committee to tell us how these three policies in this rule should be different.

Delaying and delaying through a series of moratoriums only succeeds in throwing taxpayer dollars out the window.

This rule is intended to fix another example of how states had incentives to transfer their obligations to the Medicaid program’s funding stream. States used Medicaid case management to fund their foster care systems, juvenile justice programs, and adult protective services.

The state of Washington had used Medicaid to fund non-Medicaid activities. The state legislature has now done the right thing and appropriated $17 million to replace the reduced Medicaid funding after the TCM regulation was published. If the state legislators in Washington can live up to their obligations, why should we not expect that of the other states?

Medicaid has become well known as the budget filler for states. If funding was short, find someway to call it Medicaid and state costs will be cut at least in half.

This is a dangerous path. If Medicaid keeps picking up the tab for schools or foster care or the correctional system, then we are simply inviting even larger raids on the Federal Treasury in the future.

**A provision that will prevent health coverage for low-income children doesn’t belong in a bill to provide funding for American troops.**

Hidden in a bill intended to provide funding for our troops at war is an unrelated provision that would have the effect of denying health care to low income children. The provision would impose a moratorium on a CMS directive which requires that states cover low income children before expanding their State Children’s Health Insurance Programs (SCHIP) to higher income levels. This common-sense initiative, implemented in an August 17th letter from CMS to state health officials, ensures that children’s health resources are targeted towards those children and families who need help the most. The result of the moratorium will be that states will be able to ignore the needs of low
income children and instead direct resources to families with higher incomes who are more likely to have existing health insurance coverage.

**SCHIP should focus on low-income children first.**

SCHIP was designed to cover low-income children between 100-200 percent FPL. Even though studies have shown that a significant number of children below these income levels remain uninsured, states have tried to expand coverage to higher income levels without first taking steps to make sure that they have covered as many low-income children as possible. Health coverage of low-income children must remain the number one goal of SCHIP.

The CMS August 17th letter implemented reasonable steps to ensure that states focus on low-income children before expanding their program.

The letter explains the steps that states must take to ensure that their SCHIP programs cover low-income children before expanding to higher income levels. The letter only applies to those states who wish to expand their SCHIP programs above 250 percent of the federal poverty level (FPL). CBO reported that fewer than 20 states offer coverage above this income threshold. Additionally, on May 7th CMS issued a letter clarifying the August 17th letter and specifying that current enrollees would not be impacted and that the agency would work with states to show they are meeting the requirements.

CBO showed that covering families at higher income levels is an inefficient use of taxpayer dollars.

The CBO has repeatedly stated its views that expanding SCHIP to families at higher income levels will result in a “crowd-out” rate of up to 50 percent. That is, for every 100 children who gain coverage as a result of SCHIP, there is a corresponding reduction in private coverage of up to 50 children. The CBO estimates that 77 percent of children living in families with incomes between 200 and 300 percent of the FPL have private coverage, as do 89 percent of children in families with incomes between 300 and 400 percent of FPL.
It’s wrong to take away seniors’ choices in hospitals, and it’s wrong to do that on a war supplemental so it can’t be debated out in the open.

Americans enjoy the highest per capita GDP among large nations mainly because we have the highest rate of productivity gains. The hospital sector sorely needs productivity-enhancing innovations like specialty hospitals.

U.S. health care costs are the world’s highest at 16% of GDP, creating major problems for Americans and their employers.

For example, General Motors’ financial woes are exacerbated by $1,500 of health care costs per car, which exceeds their cost of steel.

Hospitals are the largest component of our health care costs, accounting for over one-third of our $2.2 trillion health care system. They are also the major reason for the growth in costs.

According to a recent article in Forbes Magazine, 1 in 200 patients who spend a night or more in a hospital will die from medical error. The same article continues, “1 in 16 will pick up an infection. Deaths from preventable hospital infections each year exceed 100,000, more than those from AIDS, breast cancer and auto accidents combined.”

Specialty hospitals have consistently offered high-quality healthcare with high-quality outcomes. Risk-adjusted 30-day mortality rates were significantly lower for specialty hospitals than for community hospitals, according to a 2006 Health Affairs article.

There are 200 specialty hospitals in the U.S. out of the 6,000 hospitals overall, often delivering better, safer services at lower costs.

According to a recent University of Iowa study, Medicare patients who receive hip or knee replacement at specialty orthopedic hospitals have a 40 percent lower risk of complications after surgery (bleeding, infections, or death) compared to Medicare patients at general hospitals. A 2006 study funded by Medicare found that patients of all types are four times as likely to die in a full-service
hospital after orthopedic surgery as they would after the same procedure in a specialty hospital.iii

McBride Clinic in Oklahoma City is Oklahoma’s best hospital for overall orthopedic services, according to the Tenth Annual HealthGrades Hospital Quality in America Study released last month. McBride has 5-star ratings in joint replacement, total knee replacement, hip fracture repair, spine surgery, and back and neck surgery. The hospital received HealthGrades’ 2008 Orthopedic Surgery Excellence Award, and is the only Oklahoma hospital among the top five percent in the nation for overall orthopedic services.

When it comes to specialization, the question is not whether to specialize, but rather how to do it. Everyone agrees that the health care system should provide focused, integrated care—especially for the victims of chronic diseases and disability who account for 80% of costs.

For example, Duke Medical Center tried an integrated, supportive program for congestive heart failure. The approach resulted in better patient outcomes, increased patient compliance with their doctor’s recommendations, and a 32 percent drop in costs per patient. Hospital admission and lengths of stay dropped and visits to cardiologists increased nearly six-fold.

Some contend that physicians who invest in specialty hospitals have a conflict of interest that may lead to over-utilization. But a recent study published in Health Affairs found that most physicians refer patients to specialty hospitals for reasons totally unrelated to profits.

The Medicare Payment Advisory Commission (MedPAC) has also found no evidence that overall utilization rates in communities with specialty hospitals rise more rapidly than the utilization rates in other communities. MedPAC and the Centers for Medicare and Medicaid Services (CMS) have found no evidence that physicians who have an ownership interest in a specialty hospital inappropriately refer patients to that hospital or have increased utilization.

The connection between corporate ownership and performance is a bulwark of our economy. Adam Smith argued in 1776,
“The directors of . . . [joint-stock] companies, . . . being the managers rather of other people’s money than of their own, it cannot well be expected, that they should watch over it with the same anxious vigilance with which the partners in a private copartnery frequently watch over their own. Negligence and profusion, therefore, must always prevail…”

One CEO of an orthopedic surgery practice said, “Orthopedists...in a hospital...work in the same operating room [as] general surgery and obstetrics. Orthopedics is nuts-and-bolts equipment intensive. It drives them crazy to have a staff that’s not familiar with a tray of multi-size screws and nuts and bolts.”

Some object to specialty hospitals by arguing that they only select the most profitable cases in their area and leave the other hospitals with less profitable services (burn units, trauma centers, etc.). MedPAC has recommended changing the payments for all acute care hospitals to reduce the incentives in the overall inpatient payment system that some believe fueled the growth of specialty hospitals. Based on those MedPAC recommendations, CMS has just implemented major In- Prospective Payment System reforms.

There is also an abundance of evidence that community hospitals are making record profits. A recent news article reported, “Profits for U.S. general acute-care hospitals hit a record high of $35.2 billion in 2006—a one-year jump of more than 20%—on net revenue of $587.1 billion for a margin of 6%.”

We should resist efforts to bind our health care system in regulatory straightjackets. Both the hospitals’ and economy’s problems could be solved if we allow the market, rather than insurance bureaucrats, to set prices.

If the Members of the Senate really believe that specialty hospitals are harmful, then there shouldn’t be earmarks protecting the specialty hospitals in home states of certain Members of the Appropriations Committee.

According to a recent Congressional Quarterly (CQ) article, during the committee process, 4 Democrats on the Senate Appropriations Committee made language changes to the underlying ban on new growth of physician-owned hospitals
that happen to protect the specialty hospitals that are located in their home states.

According to CQ, “A spokesman for [one Appropriations Member] confirmed that [that Member] had sought the changes, to protect a physician-owned hospital in [their state]: Wenatchee Valley Medical Center. A loosening of the grandfather clause will allow the Wenatchee’s physician-owners to maintain their 100 percent stake in the hospital, as opposed to being forced to sell part of it.”

According to CQ, spokesmen for [two other Appropriations Members] confirmed their Senators’ roles in getting the language changes.

One Senator’s spokesman claimed, “We were concerned that forced divestiture would cripple the marketplace.”

In Michigan, the home state of another Appropriator, physician-owned Aurora BayCare Medical Center would benefit from the looser rules passed by the Appropriations Committee.

If Congress really believes specialty hospitals are harmful, why are they not harmful in the home states of 4 Appropriators?

The Congressional Budget Office needs to get its story straight on the budgetary impact of killing specialty hospitals.

Congress has heard from the hospital association groups about the potential cost savings from eliminating the potential for new specialty hospitals. That argument is untenable when the Congressional Budget Office can’t even get their story right on the budget impact. If 3 years ago, eliminating specialty hospitals barely saved anything how can it save billions of dollars today?

During the drafting of the Deficit Reduction Act of 2005, the Senate reconciliation bill contained a similar provision to curtail specialty hospitals. At that time, the Congressional Budget Office (CBO) projected less than minimal savings to the Medicare program resulting from that provision.
Subsequently, CBO scored a similar provision in the Children’s Health and Medicare Protection Act of 2007. This time they changed their story and projected Medicare savings of $700 million over 5 years and $2.9 billion over ten years, with the bulk of the projected savings attributed to the assumption that Medicare spends more for outpatient services for patients treated in physician-owned hospitals.

In December of 2007, CBO changed its story again and attributed the savings from restricting specialty hospitals to a presumed shift of services to ambulatory surgical centers, admitting that the use of fewer outpatient services accounts for only a small portion of the estimated savings.

This bill has troops fighting to keep birth control prices low for Ivy League students and profits high for Planned Parenthood clinics and drug companies.

Congressional leaders are using the War Supplemental Appropriations bill to expand preferential governmental drug pricing policies to university based clinics and more Planned Parenthood clinics than currently allowed under the Medicaid statute and regulations.

To have their products available in the Medicaid program, drug manufacturers must pay rebates to the federal government and states. The rebates are calculated as the difference between the manufacturer’s average price and the “best price” (lowest) at which their drugs are sold.

A tiny provision tucked away in a war supplemental will allow drug manufacturers to avoid counting these deeply discounted drugs sold to certain types of clinics when calculating how much they will owe the Medicaid program in rebates, thereby protecting their profits. If the provision becomes law, the clinics could receive cheaper drugs—like RU-486 and birth control—from manufacturers which they can sell to their customers at a higher price, thereby making a profit.

Manufacturers previously offered high volume clinics the discounts as a marketing tool to attract long-term loyal customers so long as they could avoid the Medicaid rebate. Taxpayers were in effect subsidizing these clinics by forfeiting Medicaid rebates. In the Deficit Reduction Act
of 2005 (DRA), Congress limited the types of health care clinics that can benefit from this special arrangement, providing the preferential treatment only to certain safety net clinics. Not convinced by arguments that college campus health clinics are serving “vulnerable populations,” the Bush Administration refused to add them and additional Planned Parenthood clinics to the list of providers designated by Congress.

The Deficit Reduction Act didn’t prevent drug manufacturers from selling their products at lower acquisition costs to any health clinic regardless of the DRA. They would not, however, be able to avoid counting those discounts when paying states and the federal government their respective Medicaid rebates. Auditors in California found two Planned Parenthoods had overbilled the Medicaid program in excess of $5 million based on the difference between their customary fees and acquisition costs. This suggests that restoring these subsidies nationwide is likely worth hundreds of millions of dollars over just a few years.

The current congressional leadership’s usual approach towards drug companies is to get higher rebates from them. However, that’s not the case when it comes to forfeiting rebates for the Medicaid program in order to make certain frat boys and sorority sisters get cheap drugs—including birth control—and the clinics that provide them get bigger profits.

Instead of debating the merits of such a policy change in the open, the leaders in Congress are using funding for our troops to slip this through.

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