(Mrs. BOXER) was added as a cosponsor of S. 1487, a bill to amend the Help America Vote Act of 2002 to require an individual, durable, voter-verified paper record under title III of such Act, and for other purposes.

S. 1502

At the request of Mr. CONRAD, the name of the Senator from Iowa (Mr. GRASSLEY) was added as a cosponsor of S. 1502, a bill to amend the Food Security Act of 1985 to encourage owners and operators of privately-held farm, ranch, and forest land to voluntarily make their land available for access by the public under programs administered by States and tribal governments.

S. 1514

At the request of Mr. DODD, the names of the Senator from New Mexico (Mr. DOMENICI) and the Senator from Iowa (Mr. HARKIN) were added as cosponsors of S. 1514, a bill to revise and extend provisions under the Garrett Lee Smith Memorial Act.

S. 1523

At the request of Mrs. BOXER, the names of the Senator from Virginia (Mr. WARNER), the Senator from Kentucky (Mr. MCCONNELL) and the Senator from Connecticut (Mr. LIEBERMAN) were added as cosponsors of S. 1523, a bill to amend the Clean Air Act to reduce emissions of carbon dioxide from the Capitol power plant.

S. 1557

At the request of Mr. DODD, the names of the Senator from Washington (Mrs. MURRAY) and the Senator from South Dakota (Mr. JOHNSON) were added as cosponsors of S. 1557, a bill to amend part B of title IV of the Elementary and Secondary Education Act of 1965 to improve 21st Century Community Learning Centers.

S. CON. RES. 3

At the request of Mr. SALAZAR, the names of the Senator from Pennsylvania (Mr. CASEY) and the Senator from Connecticut (Mr. LIEBERMAN) were added as cosponsors of S. Con. Res. 3, a concurrent resolution expressing the sense of Congress that it is the goal of the United States that, not later than January 1, 2025, the agricultural, forestry, and working land of the United States should provide from renewable resources not less than 25 percent of the total energy consumed in the United States and continue to produce safe, abundant, and affordable food, feed, and fiber.

S. RES. 201

At the request of Mr. CHAMBLISS, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of S. Res. 201, a resolution supporting the goals and ideals of ''National Life Insurance Awareness Month''.

S. RES. 203

At the request of Mr. MENENDEZ, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. Res. 203, a resolution calling on the Government of the People's Republic of China to use its unique influence and economic leverage to stop genocide and violence in Darfur, Sudan.

S. RES. 215

At the request of Mr. ALLARD, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. Res. 215, a resolution designating September 25, 2007, as ''National First Responder Appreciation Day''.

S. RES. 224

At the request of Mrs. FEINSTEIN, the name of the Senator from Hawaii (Mr. AKAKA) was added as a cosponsor of S. Res. 224, a resolution expressing the sense of the Senate regarding the Israeli-Palestinian peace process.

AMENDMENT NO. 1415

At the request of Mrs. HUTCHISON, the name of the Senator from Nevada (Mr. ENSIGN) was withdrawn as a cosponsor of amendment No. 1415 proposed to S. 1348, a bill to provide for comprehensive immigration reform and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. INHOFE (for himself and Mr. COBURN):

S. 1585. A bill to designate the Department of Veterans Affairs Outpatient Clinic in Tulsa, Oklahoma, as the ''Ernest Childers Department of Veterans Affairs Outpatient Clinic''; to the Committee on Veterans' Affairs.

Mr. INHOFE. Mr. President, I rise today for myself and on the behalf of my colleague, Dr. COBURN, to reintroduce a bill to honor the memory of an American hero and proud son from our great State of Oklahoma. Ernest Childers was the first Native American to receive the Congressional Medal of Honor. This is our Nation's highest military award and it was awarded to him by Congress ''for conspicuous gallantry and intrepidity at risk of life above and beyond the call of duty in action.''

Ernest Childers was born in Broken Arrow, Oklahoma, on February 1, 1918 as the third of five children. His father died when he was young and he grew up mostly on a farm. His hunting skills in his youth provided much of the food for his family and formed the basis of a great military career.

Ernest Childers enlisted in the Oklahoma National Guard in 1937 while attending the Chilocco Indian School in north-central Oklahoma. He then went to Fort Sill in Lawton, Oklahoma, for basic training before being deployed to Africa in World War II. On September 22, 1943, despite a broken instep that forced him to crawl, Second Lieutenant Childers advanced against enemy machine gun nests in Oliveto, Italy, killing two snipers and capturing an enemy mortar observer in the process. His actions were instrumental in helping the Americans win the Battle of Oliveto and won him the Congressional Medal of Honor. He continued his career in the Army earning several other military awards including the Combat Infantry Badge, Europe and Africa Campaign Medals, The Purple Heart, The Bronze Star, and the Oklahoma Distinguished Service Cross. He retired from the Army in August of 1965 as a lieutenant colonel in Oklahoma's 45th Infantry Division.

Ernest Childers passed away on March 17, 2005, and was Oklahoma's last Congressional Medal of Honor winner still living in the State. He was an honored guest of many Presidential inaugurations and as a Creek Indian, was named Oklahoma's Most Outstanding Indian by the Tulsa Chapter of the Council of American Indians in 1966. He once said ''The American Indian has only one country to defend, and when you're picked on, the American Indian never turns his back.'' I am proud and believe it is only appropriate to introduce once again this year a bill to rename the Department of Veterans Affairs' Outpatient Clinic in Tulsa, Oklahoma, the Ernest Childers Department of Veterans Affairs Outpatient Clinic to honor the enduring legacy of a true hero and fine soldier. I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 1585

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. DESIGNATION OF ERNEST CHILDERS DEPARTMENT OF VETERANS AFFAIRS OUTPATIENT CLINIC.

(a) DESIGNATION.—The Department of Veterans Affairs Outpatient Clinic in Tulsa, Oklahoma, shall be known and designated as the ''Ernest Childers Department of Veterans Affairs Outpatient Clinic''.

(b) REFERENCES.—Any reference in any law, regulation, map, document, record, or other paper of the United States to the outpatient clinic referred to in subsection (a) shall be considered to be a reference to the ''Ernest Childers Department of Veterans Affairs Outpatient Clinic''.

By Mr. BINGAMAN (for himself, Mr. KERRY, Mr. AKAKA, Mr. SALAZAR, Mr. WHITEHOUSE, and Ms. MIKULSKI):

S. 1589. A bill to amend title XIX of the Social Security Act to reduce the costs of prescription drugs for enrollees of Medicaid managed care organizations by extending the discounts offered under fee-for-service Medicaid to such organizations; to the Committee on Finance.

Mr. BINGAMAN. Mr. President, I rise today to with Senators KERRY, AKAKA, SALAZAR and WHITEHOUSE to introduce the Drug Rebate Equalization Act of 2007.

As you know, the Medicaid drug rebate ensures that State Medicaid programs receive the best price for prescription drugs for their beneficiaries. Unfortunately, health plans that serve over 10 million Medicaid beneficiaries cannot access the same discounts

through the Federal drug rebate program. Plans typically get no rebate on generic drugs and about a third of the rebate on brand drugs as States receive. Therefore, States are paying more for the acquisition of prescription drugs for these health plan enrollees than for beneficiaries in fee-for-service Medicaid, raising costs for Federal and State governments.

Even with this price disadvantage, the total cost of prescription drugs for health plans is less on a per member per month basis because of health plans' greater use of generics and case management. Unfortunately, many States are considering carving prescription drugs out from health plans for the sole purpose of obtaining the rebate, thereby undermining plans' ability to maintain a comprehensive care and disease management program that includes prescription drugs. Not only will this legislation save money, it will eliminate this incentive and ensure that health plans can maintain a comprehensive care coordination system for their patients.

This policy change was passed by the Senate during last year's debate over the Deficit Reduction Act. This year's version of the bill improves on last year's bill in several important ways. First, the bill ensures that health plans can continue their good work by using their own integrated care coordination and disease management protocols. Second, the bill will maintain the fee-for-service prohibition against health plans ''double dipping'' into the Medicaid drug rebate and the 340b discount drug pricing program. Finally, it will ensure that plans can use so-called positive formularies while simultaneously ensuring that enrollees will have access to off-formulary drugs through the regulated prior authorization process. These changes significantly improve the bill and will help improve its chances of passage.

This policy enjoys widespread support. Extending the Medicaid drug rebate to enrollees in health plans is supported by the National Governors Association, the National Association of State Medicaid Directors, the National Medicaid Commission, the National Association of Community Health Centers, the Partnership for Medicaid, the Association for Community Affiliated Plans, and the Medicaid Health Plans of America. I am entering into the record copies of letters provided by these organizations over the last few years memorializing their support for this concept.

Last year, the Congressional Budget Office estimated that the Bingaman amendment would have saved Federal taxpayers $1.7 billion over 5 years. Likewise, the CMS Office of the Actuary estimated that extending the drug rebate to health plans would save Federal taxpayers $2.2 billion over 5 years. I think that we can say that this policy will provide significant savings to Americans, whatever the number.

I urge my colleagues to join me in supporting this legislation.

I ask unanimous consent that the text of the bill and letters of support be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 1589

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Drug Rebate Equalization Act of 2007''.

SEC. 2. EXTENSION OF PRESCRIPTION DRUG DISCOUNTS TO ENROLLEES OF MEDICAID MANAGED CARE ORGANIZATIONS.

(a) IN GENERAL.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended—

(1) in clause (xi), by striking ''and'' at the end;

(2) in clause (xii), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(xiii) such contract provides that (I) payment for covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1927 as the State is subject to and that the State shall allow the entity to collect such rebates from manufacturers, and (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates.''.

(b) CONFORMING AMENDMENTS.—Section 1927 (42 U.S.C. 1396r–8) is amended—

(1) in subsection (d)—

(A) in paragraph (1), by adding at the end the following:

''(C) Notwithstanding the subparagraphs (A) and (B)—

''(i) a medicaid managed care organization with a contract under section 1903(m) may exclude or otherwise restrict coverage of a covered outpatient drug on the basis of policies or practices of the organization, such as those affecting utilization management, formulary adherence, and cost sharing or dispute resolution, in lieu of any State policies or practices relating to the exclusion or restriction of coverage of such drugs; and

''(ii) nothing in this section or paragraph (2)(A)(xiii) of section 1903(m) shall be construed as requiring a medicaid managed care organization with a contract under such section to maintain the same such polices and practices as those established by the State for purposes of individuals who receive medical assistance for covered outpatient drugs on a fee-for service basis.''; and

(B) in paragraph (4), by inserting after subparagraph (E) the following:

''(F) Notwithstanding the preceding subparagraphs of this paragraph, any formulary established by medicaid managed care organization with a contract under section 1903(m) may be based on positive inclusion of drugs selected by a formulary committee consisting of physicians, pharmacists, and other individuals with appropriate clinical experience as long as drugs excluded from the formulary are available through prior authorization, as described in paragraph (5).''; and

(2) in subsection (j), by striking paragraph (1) and inserting the following:

''(1) Covered outpatients drugs are not subject to the requirements of this section if such drugs are—

''(A) dispensed by a health maintenance organization other than a medicaid managed care organization with a contract under section 1903(m); and

''(B) subject to discounts under section 340B of the Public Health Service Act.''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on the date of enactment of this Act and apply to rebate agreements entered into or renewed under section 1927 of the Social Security Act (42 U.S.C. 1396r–8) on or after such date.

CONTROLLING PHARMACEUTICAL COSTS THROUGH GREATER EFFICIENCIES AND BETTER ADMINISTRATION OF THE DRUG REBATE PROGRAM

BACKGROUND

Medicaid fee-for-service and managed care spent an estimated $36.8 billion in FY 2003 on pharmaceuticals. Prescription drugs are one of the fastest growing categories of Medicaid expenditures, having quadrupled between 1992 and 2003. Between 2000 and 2003, spending on drugs increased by 17 percent per year, faster than any other major type of Medicaid service. In 1998, less than 8 percent of Medicaid expenditures were for drugs—by 2003 drugs claimed over 13 percent. After 2006 drugs for Medicare beneficiaries will be paid for by Medicare. These recipients currently account for about half of all Medicaid drug spending. State Medicaid programs will still be responsible for the drug costs of children and families and other non-Medicare eligibles.

Drugs are paid for by Medicaid through 3 separate mechanisms. First, the state pays the pharmacists for the ingredient costs of the drug. Previously, most states paid pharmacists based on the average wholesale price (AWP) less some percentage. AWP is the average list price that a manufacturer suggests wholesalers charge pharmacies. Federal reimbursements to states for state spending on certain outpatient prescription drugs are subject to ceilings called federal upper limits (FULs), also known as the maximum allowable cost (MAC). The effect of the FUL is to provide a financial incentive to pharmacies to substitute lower-cost ''generic'' equivalents for brand-name drugs. The Deficit Reduction Act (DRA) expanded the impact of FULs by applying them to multiple source drugs for which the FDA has rated at least 1 other drug (instead of the previous 2) to be therapeutically and pharmaceutically equivalent. The DRA also changed the FUL formula from a percentage of the AWP to a percentage of the Average Manufacturer Price (AMP), which is the average price paid to a manufacturer by wholesalers. For those drugs, the FUL would be equal to 250 percent of the AMP. The result of the AWP-to-AMP change is to make Medicaid pharmaceutical payments closer to actual cost. The DRA also expanded the required reporting of AMP and best price data, allowing states to have access to reported AMP data for the first time, and requiring HHS to make AMP data available to the public.

Second, the states pay the pharmacists a dispensing fee which typically ranges from $3 to $5 per prescription. This fee is expected to cover a wide range of services associated with dispensing drugs to Medicaid patients. The need to adequately reimburse pharmacists for these services was recognized by Congress under the Medicare Modernization Act of 2003, which included a provision requiring Medicare Part D drug plans to reimburse pharmacists for ''medication therapy management services'' administered to patients with multiple chronic conditions.

Third, states receive a rebate directly from the manufacturers based on their utilization. The brand name rebate is the greater of a flat rebate amount of 15.1 percent of average manufacturers price (AMP) or the difference between AMP and the best price offered to any nongovernmental buyer. Manufacturers

have to pay an additional rebate if their drug prices have risen faster than the rate of general inflation. The DRA also made limited changes to the Medicaid drug rebate program. In addition, some states have entered into supplemental rebate agreements with manufacturers in return for putting their drugs on a preferred drug list. CBO estimates that the average rebate received by the states equaled 31.4 percent of AMP with the average basic rebate of 19.6 percent and the inflation adjustment rebate equal to 11.7 percent. States also receive a rebate on generic drugs of 11 percent of AMP. In return for the rebates, states must provide access to all FDA-approved drugs, although they may and do have extensive prior authorization programs, step therapy, limited prescriptions per month and co-payments.

Medicaid managed care plans do not receive the statutory rebate levels, and instead must negotiate rebates on their own.

ISSUES TO CONSIDER

Administration of the rebate program is inadequate. The Government Accountability Office has found significant shortcomings in the Centers for Medicare and Medicaid Services' (CMS) administration of the Medicaid drug rebate program, including lack of clear guidance to manufacturers for determining AMP, poor reporting of certain group purchase prices in setting ''best price'' levels, and limited audits of manufacturer price setting methods. Moreover, the Health and Human Services (HHS) Office of the Inspector General (OIG) recently found that CMS's failure to add qualified new drugs to the Federal upper limit list had resulted in state Medicaid programs paying more than they otherwise would have for these drugs. Changes to the rebate program in the DRA are minimal and are not expected to have a major effect on it.

Reimbursement is not reflective of the true costs of drugs and pharmacy services. The DRA-driven changes in pharmaceutical acquisition prices, by moving to an AMP-based system, may result in some system savings, though how much is not clear. However, the dispensing fee is also considered by many to be inadequate for reimbursing pharmacists for the range of services they provide. These services may include managing inventory, counseling patients on proper medication use, and complying with federal and state regulations in addition to storing, warehousing, and dispensing the drug. Without an adequate dispensing fee, some pharmacies may elect not to participate in Medicaid rather than assume financial loss.

Exemption for managed care plans inefficient. Over 10 million Medicaid beneficiaries receive their drugs through Medicaid managed care plans which do not have access to the Medicaid drug rebate. Under the drug rebate, States receive between 18 and 20 percent discounts on brand name drug prices and between 10 and 11 percent for generic drug prices. According to a recent study, Medicaid-focused managed care organizations (MCOs) typically only receive about a 6 percent discount on brand name drugs and no discount on generics. Because many MCOs (particularly smaller Medicaid-focused MCOs) do not have the capacity to negotiate deeper discounts with drug companies, Medicaid is overpaying for prescription drugs for enrollees in Medicaid health plans. The Congressional Budget Office (CBO) recently estimated that this change would save $2 billion over 5 years.

POTENTIAL SOLUTIONS

Tighten administration of the rebate program. Inconsistent and inaccurate calculations of AMP, best price, and other components of the rebate formula have cost Medicaid millions of dollars. By improving CMS oversight over the program and increasing manufacturer accountability over proper calculation of rebates, Medicaid would reap the full benefits of the Medicaid drug rebate program.

Increase the basic level of rebate. CBO has estimated that setting the basic rebate level at 23 percent would result in savings of $3.2 billion over 5 years. Available information supports setting the rebate at a higher level than it is at today.

Payment for pharmacist services should be realigned to reflect true costs, including medication therapy management services. With the Congress having addressed the issue of pharmaceutical acquisition prices, now is the appropriate time to adjust reimbursement for pharmacists' services to reflect their increased role in managing medication-based therapies, counseling patients, and providing other critical pharmacy services to Medicaid patients.

Encourage evidence-based formularies where appropriate. Development of formularies should provide access to necessary treatments, and encourage and support benefit management best practices that are proven in widespread use today. Effectiveness, not cost, should be the main objective when developing formularies. The goal is for plans to provide high-quality, cost-effective drug benefits by using effective drug utilization management techniques. Although effectiveness data do not exist for all classes of medications, and are not appropriate for certain populations, well-designed evidence-based formularies that take into account comparative effectiveness data have the potential to provide access to high quality, cost-effective medications.

Allow Medicaid managed care plans to have access to the drug rebate for non-340B drugs. All Medicaid beneficiaries should have their drug costs reduced to the maximum extent possible, either by the Medicaid rebate or by the 340B program. While recognizing that managed care plans should have access to the Medicaid drug rebate, it is also important to be mindful of the need to protect 340B-covered entities from the risk of creating a ''duplicate discount'' due to the overlap of the rebate and the 340B program.

Extend the 340B drug discount to Inpatient Pharmaceuticals. The Safety Net Inpatient Drug Affordability Act (S. 1840/H.R. 3547) would require that 340B hospitals and Critical Access Hospitals rebate Medicaid a significant portion of their 340B savings on inpatient drugs administered to Medicaid patients. In addition, to the extent that any Critical Access Hospitals operate outpatient pharmacies, they would be required to pass through to Medicaid their 340B savings for Medicaid patients. These savings to Medicaid also accrue to taxpayers by reducing costs for federal, state and local governments. The proposal allows health care providers to stretch limited resources as they care for America's neediest populations. The Public Hospital Pharmacy Coalition (PHPC) estimates that the Safety Net Inpatient Drug Affordability Act (S. 1840/H.R. 3547) would provide significant savings to the Medicaid program and lower costs for taxpayer-supported safety net institutions that care for low-income and uninsured patients. PHPC estimates that this legislation would reduce Medicaid costs by over $100 million per year.

AMERICAN PUBLIC HUMAN SERVICES ASSOCIATION, NATIONAL ASSOCIATION OF STATE MEDICAID DIRECTORS

POLICY STATEMENT: MCO ACCESS TO THE MEDICAID PHARMACY REBATE PROGRAM

Background

The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) established a Medicaid drug rebate program that requires pharmaceutical manufacturers to provide a rebate to participating state Medicaid agencies. In return, states must cover all prescription drugs manufactured by a company that participates in the rebate program. At the time of this legislation, only a small percentage of Medicaid beneficiaries were enrolled in capitated managed care plans and were primarily served by plans that also had commercial lines of business. These plans requested to be excluded from the drug rebate program as it was assumed that they would be able to secure a better rebate on their own. Though regulations have not yet been promulgated, federal interpretation to date has excluded Medicaid managed care organizations from participating in the federal rebate program.

Today, the situation is quite different. 58% of all Medicaid beneficiaries are enrolled in some type of managed care delivery system, many in capitated health plans. Some managed care plans, especially Medicaid-dominated plans that make up a growing percentage of the Medicaid marketplace, are looking at the feasibility of gaining access to the Medicaid pharmacy rebate. However, a number of commercial plans remain content to negotiate their own pharmacy rates and are not interested in pursuing the Medicaid rebate.

Policy Statement

The National Association of State Medicaid Directors is supportive of Medicaid managed care organizations (MCOs), in their capacity as an agent of the state, being able to participate fully in the federal Medicaid rebate program. To do so, the MCO must adhere to all of the federal rebate rules set forth in OBRA '90 and follow essentially the same ingredient cost payment methodology used by the state. The state will have the ability to make a downward adjustment in the MCO's capitation rate based on the assumption that the MCO will collect the full rebate instead of the state. Finally, if a pharmacy benefit manager (PBM) is under contract with an MCO to administer the Medicaid pharmacy benefit for them, then the same principal shall apply, but in no way should both the MCO and the PBM be allowed to claim the rebate.—Approved by NASMD June 24, 2002

We oppose the Senate provision that provides for mandatory dispensing fee guidelines. States welcome more research in dispensing fees throughout the US health care system. Currently, there is very little information for states to use when considering appropriate dispensing fees. New reference information would be helpful; but mandatory guidelines should not be imposed on states.

The effective date for any dispensing fee provisions should be the date 6 months after the close of the first regular state legislative session. A state may need extra time to implement a pharmacy reimbursement system to determine appropriate dispensing fees and make changes to separate out the dispensing fee from the reimbursement in their systems.

Governors should maintain flexibility to establish dispensing fees to maintain access to both pharmacies that may provide specialty services as well as those that serve beneficiaries in rural and underserved areas. Limiting such pharmacies by arbitrary federal statutory definitions or regulation will not help states to manage their pharmacy programs. New federal mandates on how to consider dispensing fees for such pharmacists are unnecessary and burdensome.

Preferred Drug List Restriction: NGA opposes House provision

The House provision (SEC.3105) that would limit states' current ability to include mental health drugs on a state's preferred drug

list should be dropped from the final bill. This provision would be very costly—far beyond the $120 million estimated by the Congressional Budget Office—and would undermine states current ability to use commonsense tools that are used throughout the health care system to manage expensive mental health drugs. For example, Texas estimates the provisions federal impact from its state would be a cost of $50 million over five years and California alone estimates $250 million cost to the federal government over the five year budget window.

Tiered Co Pays for Prescription Drugs: NGA supports House provision with modification

The House provision that would allow states to use tiered co-pays to encourage use of more affordable drugs should be maintained in the final package; however, the provision that limits this flexibility and otherwise links Medicaid program administration to TRICARE-approved formularies should be dropped.

Rebates: NGA supports some Senate provisions, one with modification

The Senate provision that would increase minimum rebates on brand name drugs should be maintained in the final bill.

The Senate provision that extends rebates to managed care organizations that care for Medicaid beneficiaries should be maintained in the final bill.

Regarding the requirement in both the House and Senate bill for states to collect rebates on physician administered drugs, the provision in the House bill that provides for a hardship waiver for those states that require additional time to implement the reporting system required to collect these rebates should be maintained in the final bill.

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC.,
Washington, DC, August 18, 2005.

MARGARET A. MURRAY,
Executive Director, Association for Community Affiliated Plans, Washington, DC.

DEAR MS. MURRAY. The National Association of Community Health Centers (NACHC), the national trade organization representing America's 1,100 federally qualified health centers, has reviewed your proposed initiative to provide Medicaid managed care organizations with access to the Medicaid drug rebate found in Section 1927 of the Social Security Act.

ACAP and NACHC share a very special relationship. Many of ACAP's member plans are owned and governed by community health center representatives. This unique relationship often creates a mutual policy interest and this proposal is an example of such an intersection.

Your proposal to allow Medicaid managed care organizations access to the Medicaid drug rebate makes sense given the migration of Medicaid beneficiaries from fee-for-service to managed care since 1990. Increasingly, states have not been able to take advantage of the drug rebate for those enrollees in managed care, thus driving up federal and state Medicaid costs. The savings estimated in the Lewin Group study are significant and may help to mitigate the needs for other cuts in the program. In addition, it demonstrates a proactive effort to offer solutions to improving the Medicaid program. We applaud this effort.

While we are deeply concerned that Congress may engage in budget-driven, rather than policy-driven, efforts to restrain or reduce Medicaid spending, we also recognize that—as providers to a substantial portion of the Medicaid-enrolled population—we have a responsibility to put forth viable, realistic alternatives that can help slow the growth on Medicaid spending without throwing people off the rolls, or cutting benefits or payment rates, Your proposal offers just such a common-sense solution, one that we would be pleased to support in the event that the Congress acts to constrain costs without undermining the fundamental goals of the program.

Sincerely,
DANIEL R. HAWKINS, Jr.,
Vice President for Federal, State, and Public Affairs.

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS,
Washington, DC, June 5, 2007.

HON. JEFF BINGAMAN,
Hart Senate Office Building, Washington, DC.

DEAR SENATOR BINGAMAN: On behalf of the Association of Community Affiliated Plans (ACAP), our 32 member health plans, and over four million Americans they serve, I am writing to express our gratitude and support for your legislation to extend the benefits of the Medicaid drug rebate to the Medicaid beneficiaries enrolled in Medicaid health plans.

Created by the Omnibus Budget Reconciliation Act (OBRA) of 1990, the Medicaid Drug Rebate Program requires a drug manufacturer to have a rebate agreement with the Secretary of the Department of Health and Human Services for States to receive federal funding for outpatient drugs dispensed to Medicaid patients. At the time the law was enacted, managed care organizations were excluded from access to the drug rebate program. In 1990, only 2.8 million people were enrolled in Medicaid managed care and so the savings lost by the exemption were relatively small. Today, 18 million people are enrolled in capitated managed care plans. Pharmacy costs in Medicaid Fee-for-Service settings are 18 percent higher on a per-member-per-month basis than in the managed care setting even though plans are at a disadvantage with respect to the federal rebate. With the federal rebate as an additional tool, plans could save the Medicaid program even more.

Extending the Medicaid drug rebate to Medicaid health plans has been championed by ACAP for several years as a common sense approach to reforming the Medicaid program, while ensuring that all Medicaid beneficiaries receive the care they need. The proposal to extend the drug rebate has been endorsed by the National Governors Association, the National Association of State Medicaid Directors, the National Medicaid Commission, the Medicaid Health Plans of America, the Partnership for Medicaid, and the National Association of Community Health Centers. The Congressional Budget Office and the CMS Actuary have said that this policy will save between $1.7 billion and $2.2 billion in Federal tax dollars over 5 years.

Again, thank you for your leadership to help modernize the Medicaid program in a commonsense manner by extending the savings of the drug rebate to Medicaid health plans. Please do not hesitate to contact me if I can be of any further assistance.

Sincerely,
MARGARET A. MURRAY,
Executive Director.

MEDICAID HEALTH PLANS OF AMERICA,
Washington, DC, April 7, 2005.

Margaret A. Murray,
Executive Director, Association for Community Affiliated Plans, Washington, DC.

DEAR MS. MURRAY: The Medicaid Health Plans of America (MHPOA) supports your proposed initiative to provide Medicaid managed care organizations with access to the Medicaid drug rebate found in Section 1927 of the Social Security Act. We support this effort and urge Congress to enact this common sense provision.

Medicaid Health Plans of America, formed in 1993 and incorporated in 1995, is a trade association representing health plans and other entities participating in Medicaid managed care throughout the country. It's primary focus is to provide research, advocacy, analysis, and organized forums that support the development of effective policy solutions to promote and enhance the delivery of quality healthcare. The Association initially coalesced around the issue of national health care reform, and as the policy debate changed from national health care reform to national managed care reform, the areas of focus shifted to the changes in Medicaid managed care.

Your proposal to allow Medicaid managed care organizations access to the Medicaid drug rebate makes sense given the migration of Medicaid beneficiaries from fee-for-service to managed care since 1990. Increasingly, states have not been able to take advantage of the drug rebate for those enrollees in managed care, thus driving up federal and state Medicaid costs. The savings estimated in the Lewin Group study are significant and may help to mitigate the needs for other cuts in the program. In addition, it demonstrates a proactive effort to offer solutions to improving the Medicaid program. We applaud this effort.

MHPOA is proud to support this legislative proposal and will endorse any legislation in Congress to enact this proposal.

Sincerely,
THOMAS JOHNSON,
Executive Director.

THE MEDICAID COMMISSION

(Report to the Honorable Secretary Michael O. Leavitt, Department of Health and Human Services and The United States Congress September 1, 2005)

Proposal

The Commission recommends allowing states to establish pharmaceutical prices based on the Average Manufacturer Price (AMP) rather than the published Average Wholesale Price (AWP). Additionally, reforms should be implemented to ensure that manufacturers are appropriately reporting data. Such improvements should include reforms to ensure: (1) clear guidance from CMS on manufacturer price determination methods and the definition of AMP; (2) manufacturer-reported prices are easily auditable so that systematic oversight of the price determination can be done by HHS; (3) manufacturer-reported prices and rebates are provided to states monthly rather than the current quarterly reporting; and (4) new penalties are implemented to discourage manufacturers from reporting inaccurate pricing information.

Estimated savings

$4.3 Billion over 5 years (CMS Office of the Actuary)

EXTENSION OF THE MEDICAID DRUG REBATE PROGRAM TO MEDICAID MANAGED CARE

Current law

Section 1927 of the Social Security Act, effective January 1, 1991 sets forth the requirements of the Medicaid Drug Rebate Program. In order for Federal Medicaid matching funds to be available to States for covered outpatient drugs of a manufacturer, the manufacturer must enter into and have in effect a rebate agreement with the Federal government. Without an agreement in place, States cannot generally receive Federal funding for outpatient drugs dispensed to Medicaid recipients. Rebate amounts received by states are considered a reduction

in the amount expended by States for medical assistance for purposes of Federal matching funds under the Medicaid program.

The basic rebate for brand name drugs is the greater of 15.1 percent of the Average Manufacturer Price (AMP) or AMP minus Best Price (BP). Best Price is the lowest price at which the manufacturer sells the covered outpatient drug to any purchaser, with certain statutory exceptions, in the United States in any pricing structure, in the same quarter for which the AMP is computed.

The rebate for generic drugs is 11 percent of AMP.

Under current law Medicaid states cannot collect rebates from managed care organizations in the Medicaid Drug Rebate Program.

Proposal

The Commission recommends providing Medicaid managed care health plans access to the existing pharmaceutical manufacturer rebate program currently available to other Medicaid health plans. States should have the option of collecting these rebates directly or allowing plans to access them in exchange for lower capitation payments.

Estimated savings

$2 Billion over 5 years (CMS Office of the Actuary)

CHANGE THE START DATE OF PENALTY PERIOD FOR PERSONS TRANSFERRING ASSETS FOR MEDICAID ELIGIBILITY

Current law

States determine financial eligibility for Medicaid coverage of nursing home care using a combination of state and federal statutes and regulations. Personal income and assets must be below specified levels before eligibility can be established. Personal resources are sorted into two categories: those considered countable (those that must be spent down before eligibility criteria is met) and those considered non-countable (those that applicants can keep and still meet the eligibility criteria such as real estate that is the beneficiary's primary residence). Some assets held in trust, annuities, and promissory notes are also not counted. If it is determined that the applicant has excess countable assets, these must spent before they can become eligible. Personal income is applied to the cost of care after a personal needs allowance and a community spouse allowance is deducted.

Federal law requires states to review the assets of Medicaid applicants for a period of 36 months prior to application or 60 months if a trust is involved. This period is known as the ''look back period.'' Financial eligibility screeners look for transfers from personal assets made during the look back period that appear to have been made for the purpose of obtaining Medicaid eligibility. Transfers made before the look back period are not reviewed.

Applicants are prohibited from transferring resources during the look back period for less than fair market value. Some transfers of resources are allowed, such as transfers between spouses. If a state eligibility screener finds a non-allowed transfer, current law (OBRA 1993) requires the state to impose a ''penalty period'' during which Medicaid will not pay for long-term care. The length of the penalty period is calculated by dividing the amount transferred by the monthly private pay rate of nursing homes in the state. The penalty period starts from the date of the transfer. Using the date of the transfer as the start date provides an opportunity for applicants to preserve assets because some or all of the penalty period may occur while the applicant was not paying privately for long-term care.

We oppose the Senate provision that provides for mandatory dispensing fee guidelines. States welcome more research in dispensing fees throughout the U.S. health care system. Currently, there is very little information for states to use when considering appropriate dispensing fees. New reference information would be helpful; but mandatory guidelines should not be imposed on states.

The effective date for any dispensing fee provisions should be the date 6 months after the close of the first regular state legislative session. A state may need extra time to implement a pharmacy reimbursement system to determine appropriate dispensing fees and make changes to separate out the dispensing fee from the reimbursement in their systems.

Governors should maintain flexibility to establish dispensing fees to maintain access to both pharmacies that may provide specialty services as well as those that serve beneficiaries in rural and underserved areas. Limiting such pharmacies by arbitrary federal statutory definitions or regulation will not help states to manage their pharmacy programs. New federal mandates on how to consider dispensing fees for such pharmacists are unnecessary and burdensome.

Preferred drug list restriction

NGA opposes House provision

The House provision (Sec. 3105) that would limit states' current ability to include mental health drugs on a state's preferred drug list should be dropped from the final bill. This provision would be very costly—far beyond the $120 million estimated by the Congressional Budget Office—and would undermine states current ability to use commonsense tools that are used throughout the health care system to manage expensive mental health drugs. For example, Texas estimates the provisions federal impact from its state would be a cost of $50 million over 5-years and California alone estimates $250 million cost to the federal government over the 5-year budget window.

Tiered Co-pays for prescription drugs

NGA supports House provision with modification

The House provision that would allow states to use tiered co-pays to encourage use of more affordable drugs should be maintained in the final package; however, the provision that limits this flexibility and otherwise links Medicaid program administration to TRICARE-approved formularies should be dropped.

Rebates

NGA supports some Senate provisions, one with modification

The Senate provision that would increase minimum rebates on brand name drugs should be maintained in the final bill.

The Senate provision that extends rebates to managed care organizations that care for Medicaid beneficiaries should be maintained in the final bill.

Regarding the requirement in both the House and Senate bill for states to collect rebates on physician administered drugs, the provision in the House bill that provides for a hardship waiver for those states that require additional time to implement the reporting system required to collect these rebates should be maintained in the final bill.

By Mr. BYRD (for himself and Mr. ROCKEFELLER):

S. 1590. A bill to provide for the reintatement of a license for a certain Federal Energy Regulatory Commission project; to the Committee on Energy and Natural Resources.

Mr. BYRD. Mr. President, my colleague from West Virginia, Senator ROCKEFELLER, and I have joined together today to introduce legislation that would allow for the construction of a hydroelectric facility near the the City of Grafton, located in north central West Virginia. A companion measure is being introduced in the U.S.I House of Representatives by Congressman ALAN MOLLOHAN. The proposed hydro facility, to be constructed on an existing dam, would supply power to Grafton and surrounding area while also providing a significant economic benefit to the city.

Our legislation, which was passed by the Senate late last year but did not clear the House of Representatives before the end of the session, would reinstate a license from the Federal Energy Regulatory Commission, FERC, for a new hydroelectric facility on the Tygart Valley River. The City of Grafton has been considering the hydroelectric facility for many years, and first received a license for the project in 1989. However, that license lapsed in 1999 without the city making progress on the effort. The Byrd-Rockefeller-Mollohan measure would reinstate the license and allow Grafton to move ahead with the 20-megawatt hydroelectric facility.

The City of Grafton is working with a private contractor to develop the hydro project. With a new FERC license, the contractor believes that the project could be in operation as early as 2008. It is expected that the new hydroelectric facility would generate about $300,000 in annual revenues for Grafton, while creating 200 construction jobs in the process.

In 1938, the Tygart dam became the first flood control project to be completed in the Pittsburgh District of the Army Corps of Engineers under the Rivers and Harbors Act of 1935. It remains one of the most expensive and extensive construction projects in the history of West Virginia. I recognize that the hydroelectric project has been delayed numerous times, but the Congressional Budget Office found that implementing the project will pose zero negative impact to the Federal budget. In fact, it will generate roughly $200,000 in annual licensing fees for the U.S. Treasury. Approval of our legislation will yield a return on this previous significant investment by the American taxpayer by leveraging new value out of old infrastructure.

Clean, hydroelectric power generation from an expensive dam previously used only for flood control, at no cost to the Federal Government, is the type of cost-effective, progressive action that we should facilitate and applaud at every chance. It is the right thing to do for the communities and public utilities in the rural Appalachian counties where the existing dam and lake are located. It is the right thing to do for the West Virginians all along the Tygart and Monongahela Rivers. And it is the right thing to do for the taxpaying citizens of this Nation. I respectfully request that my colleagues support our

legislation, the bill that makes these positive results possible.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 230—DESIGNATING THE MONTH OF JULY 2007, AS ''NATIONAL TEEN SAFE DRIVER MONTH''

Mr. ISAKSON submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 230

Whereas automobile accidents involving teenage drivers result in the highest cause of death and injury for adolescents between the ages of 15 and 20 years;

Whereas, each year, 7,460 teenage drivers between the ages of 15 and 20 years are involved in fatal crashes, and 1,700,000 teenage drivers are involved in accidents that are reported to law enforcement officers;

Whereas driver education and training resources have diminished in communities throughout the United States, leaving families underserved and lacking in opportunities for educating the teenage drivers of those families;

Whereas, in addition to costs relating to the long-term care of teenage drivers severely injured in automobile accidents, automobile accidents involving teenage drivers cost the United States more than $40,000,000,000 in lost productivity and other forms of economic loss;

Whereas technology advances have increased the opportunity of the United States to provide more effective training and research to novice teenage drivers; and

Whereas the families of victims of accidents involving teenage drivers are working together to save the lives of other teenage drivers through volunteer efforts in local communities: Now, therefore, be it

Resolved, That the Senate—

(1) designates the month of July 2007 as ''National Teen Safe Driver Month''; and

(2) calls upon the members of Federal, State, and local governments and interested organizations—

(A) to commemorate National Teen Safe Driver Month with appropriate ceremonies, activities, and programs; and

(B) to encourage the development of resources to provide affordable, accessible, and effective driver training for every teenage driver of the United States.

AMENDMENTS SUBMITTED AND PROPOSED

SA 1500. Mr. PRYOR submitted an amendment intended to be proposed by him to the bill H.R. 6, to reduce our Nation's dependency on foreign oil by investing in clean, renewable, and alternative energy resources, promoting new emerging energy technologies, developing greater efficiency, and creating a Strategic Energy Efficiency and Renewables Reserve to invest in alternative energy, and for other purposes; which was ordered to lie on the table.

SA 1501. Mr. PRYOR submitted an amendment intended to be proposed by him to the bill H.R. 6, supra; which was ordered to lie on the table.

SA 1502. Mr. REID submitted an amendment intended to be proposed by him to the bill H.R. 6, supra; which was ordered to lie on the table.

SA 1503. Mr. CARDIN submitted an amendment intended to be proposed by him to the bill H.R. 6, supra; which was ordered to lie on the table.

SA 1504. Mr. CARDIN submitted an amendment intended to be proposed by him to the bill H.R. 6, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 1500. Mr. PRYOR submitted an amendment intended to be proposed by him to the bill H.R. 6, to reduce our Nation's dependency on foreign oil by investing in clean, renewable, and alternative energy resources, promoting new emerging energy technologies, developing greater efficiency, and creating a Strategic Energy Efficiency and Renewables Reserve to invest in alternative energy, and for other purposes; which was ordered to lie on the table; as follows:

On page 152, strike line 24 and insert the following:

''under subsection (a)(1).

''(g) USE OF ENERGY AND WATER EFFICIENCY MEASURES IN FEDERAL BUILDINGS.—

''(1) ENERGY AND WATER EVALUATIONS.—Not later than 1 year after the date of enactment of this subsection, and every 3 years thereafter, each Federal agency shall complete a comprehensive energy and water evaluation for—

''(A) each building and other facility of the Federal agency that is larger than a minimum size established by the Secretary; and

''(B) any other building or other facility of the Federal agency that meets any other criteria established by the Secretary.

''(2) IMPLEMENTATION OF IDENTIFIED ENERGY AND WATER EFFICIENCY MEASURES.—

''(A) IN GENERAL.—Not later than 2 years after the date of enactment of this subsection, and every 3 years thereafter, each Federal agency—

''(i) shall fully implement each energy and water-saving measure that the Federal agency identified in the evaluation conducted under paragraph (1) that has a 15-year simple payback period; and

''(ii) may implement any energy or water-saving measure that the Federal agency identified in the evaluation conducted under paragraph (1) that has longer than a 15-year simple payback period.

''(B) PAYBACK PERIOD.—

''(i) IN GENERAL.—For the purpose of subparagraph (A), a measure shall be considered to have a 15-year simple payback if the quotient obtained under clause (ii) is less than or equal to 15.

''(ii) QUOTIENT.—The quotient for a measure shall be obtained by dividing—

''(I) the estimated initial implementation cost of the measure (other than financing costs); by

''(II) the annual cost savings from the measure.

''(C) COST SAVINGS.—For the purpose of subparagraph (B), cost savings shall include net savings in estimated—

''(i) energy and water costs;

''(ii) operations, maintenance, repair, replacement, and other direct costs; and

''(iii) external environmental, health, security, and other costs based on a cost adder, as determined in accordance with the guidelines issued by the Secretary under paragraph (4).

''(D) EXCEPTIONS.—The Secretary may modify or make exceptions to the calculation of a 15-year simple payback under this paragraph in the guidelines issued by the Secretary under paragraph (4).

''(3) FOLLOW-UP ON IMPLEMENTED MEASURES.—For each measure implemented under paragraph (2), each Federal agency shall carry out—

''(A) commissioning;

''(B) operations, maintenance, and repair; and

''(C) measurement and verification of energy and water savings.

''(4) GUIDELINES.—

''(A) IN GENERAL.—The Secretary shall issue guidelines and necessary criteria that each Federal agency shall follow for implementation of—

''(i) paragraph (1) not later than 90 days after the date of enactment of this subsection; and

''(ii) paragraphs (2) and (3) not later than 180 days after the date of enactment of this subsection.

''(B) RELATIONSHIP TO FUNDING SOURCE.—The guidelines issued by the Secretary under subparagraph (A) shall be appropriate and uniform for measures funded with each type of funding made available under paragraph (8).

''(5) WEB-BASED CERTIFICATION.—

''(A) IN GENERAL.—For each building and other facility that meets the criteria established by the Secretary under paragraph (1), each Federal agency shall use a web-based tracking system to certify compliance with the requirements for—

''(i) energy and water evaluations under paragraph (1);

''(ii) implementation of identified energy and water measures under paragraph (2); and

''(iii) follow-up on implemented measures under paragraph (3).

''(B) DEPLOYMENT.—Not later than 1 year after the date of enactment of this subsection, the Secretary shall deploy the web-based tracking system required under this paragraph in a manner that tracks, at a minimum—

''(i) the covered buildings and other facilities;

''(ii) the status of evaluations;

''(iii) the identified measures, with estimated costs and savings;

''(iv) the status of implementing the measures;

''(v) the measured savings; and

''(vi) the persistence of savings.

''(C) AVAILABILITY.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall make the web-based tracking system required under this paragraph available to Congress, other Federal agencies, and the public through the Internet.

''(ii) EXEMPTIONS.—At the request of a Federal agency, the Secretary may exempt specific data for specific buildings from disclosure under clause (i) for national security purposes.

''(6) BENCHMARKING OF FEDERAL FACILITIES.—

''(A) IN GENERAL.—Each Federal agency shall enter energy use data for each building and other facility of the Federal agency into a building energy use benchmarking system, such as the Energy Star Portfolio Manager.

''(B) SYSTEM AND GUIDANCE.—Not later than 1 year after the date of enactment of this subsection, the Secretary shall—

''(i) select or develop the building energy use benchmarking system required under this paragraph for each type of building; and

''(ii) issue guidance for use of the system.

''(7) FEDERAL AGENCY SCORECARDS.—

''(A) IN GENERAL.—The Director of the Office of Management and Budget shall issue quarterly scorecards for energy management activities carried out by each Federal agency that includes—

''(i) summaries of the status of—

''(I) energy and water evaluations under paragraph (1);

''(II) implementation of identified energy and water measures under paragraph (2); and