



For Immediate Release  
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**Floor Statement of Senator Max Baucus (D-Mont.)  
Regarding The Medicare Improvements for Patients and Providers Act**

Unless we act, on July 1, the law will cut Medicare payments to doctors by ten percent. Today, we have the opportunity to vote on proceeding to a bill that will stop that cut.

In addition to averting the ten percent payment cut, the bill on which we will vote today will also make important improvements for beneficiaries. It will help those with very modest incomes to get the help that they need.

And it will expand access to preventive benefits in Medicare. And we should all agree that prevention is critical to moving our health care system from one that treats disease to one focused on wellness.

The bill includes provisions intended to give a boost to primary care physicians. These represent a down-payment on changes that I'd like to consider in the near future to advance the role of our front-line physicians.

The bill will improve access to health care in rural areas. The bill includes of many policies from the "Craig Thomas Rural Hospital and Provider Equity Act."

The bill will lend a hand to pharmacists. Pharmacists face so many challenges right now.

And the bill will help ambulance providers. Today, these first responders must contend with record high and rising gas prices.

That is what this bill will do. It is a good bill. It is a balanced bill. And it is a bill that my Colleagues should be proud to support.

Let me also talk about what this bill would not do. I have heard some of the claims made about this bill. And I would like to set the record straight.

First, this bill would not make drastic cuts to Medicare Advantage payments. This is not the House-passed CHAMP bill. Although I believe that there is justification for making significant reductions to the Medicare Advantage benchmarks, this bill would not do that. This bill would not affect the benchmarks.

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Second, this legislation would not eliminate private fee-for-service plans. What it will do instead is take away the ability of these plans to “deem” doctors and hospitals into their networks.

Right now, private fee-for-service plans are permitted to circumvent network requirements. They can deem any Medicare provider to be part of the plan network. And they can do that without a formal agreement between the provider and the private fee-for-service plan.

This means that doctors and hospitals are automatically considered by the plan to have agreed to all of the terms and conditions of the plans. They are automatically considered to have agreed to payment levels, to patient cost-sharing obligations, and to billing procedures.

It’s no wonder that we hear from providers that they don’t like dealing with these plans. I would go so far as to say that forcing doctors and hospitals to accept the terms that plans lay out — without a chance to negotiate — seems un-American.

How will this legislation address deeming? It will eliminate this deeming authority beginning in 2011. Yes, 2011. Not next year, and not in 2010, but 2011. Plans will have two and a half years to develop a network. That’s plenty of time, in my view.

Moreover, the bill will protect choice in rural areas. The deeming provisions will only affect areas where there are already two or more plan options available that have a network. In those areas, where existing plans have contracted with providers to form a network, private fee-for-service has a competitive advantage. This bill will level the playing field across all plans.

Second, this bill will not cut teaching hospitals. It will not jeopardize access to plans in areas where academic medical centers are most prevalent.

Right now, Medicare pays twice for indirect medical education on behalf of patients in Medicare Advantage plans. Medicare pays once when it reimburses teaching hospitals directly for IME costs. And Medicare pays a second time by inflating payments to Medicare Advantage plans for the same costs.

So under this bill, teaching hospitals will continue to receive IME payments directly from Medicare. But the unnecessary double payments will be eliminated.

Third, this bill will not allow wealthy seniors to qualify for low-income subsidies. The bill will raise the assets test from \$4,000 to just under \$8,000 for individuals. And it will raise the assets test from \$6,000 to \$12,000 for couples. That will give more seniors with very limited means the ability to qualify for additional subsidies.

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The income cut-offs to qualify for the subsidies will remain the same. Beneficiaries will need to have incomes below \$10,200 for the Qualified Medicare Beneficiaries program and below \$12,500 for the Specified Low-Income Medicare Beneficiaries program. That's just as under current law.

I think that we would all agree that anyone with an annual income below \$12,500 and personal assets below \$8,000 is someone whom we would want to help.

And if we can get the 60 votes to get to this bill, I will offer an amendment to delay implementation of the competitive bidding program for durable medical equipment. That is a pledge that I made to many of my Colleagues. And that is a pledge that I made publicly.

That is a promise that I intend to keep. I will offer as an amendment the language of the bipartisan bill introduced earlier today in the House by Representatives Stark, Camp, Boehner, and Pallone. Their bill is thoughtful and balanced. And it responds to many of the concerns that we have all heard from the DME industry. And if we get to this Medicare bill, we will include that language in this bill.

Another policy in S. 3101 that I intend to revisit is oxygen cuts. Congress needs to address overpayments to oxygen. In some cases, Medicare pays 1000 percent above what these supplies cost. And beneficiaries pay the price through inflated co-payment rates.

But this is a limited bill. It is not intended to fix all that ails Medicare. We will revisit oxygen payments when the Congress next takes up Medicare. By my estimates, that would be next fall, when the 18-month physician payment fix and other extender policies will expire.

In sum, time is running short. We need to complete a bill by June 30. The options before us are few, and fraught with pitfalls.

By far, the best option for getting a Medicare bill done this year is the bill on which we will vote today.

This bill is bipartisan. It is carefully balanced. And it does what we need to do.

I urge my Colleagues to vote for cloture on the motion to proceed.

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