RSC

Republican Study Committee

Rep. Sue Myrick (R-NC), Chairman
Neil Bradley, Executive Director

230 Cannon House Office Building
Washington, D.C. 20515

www.house.gov/burton/RSC

ph (202) 226-9717 • fax (202) 226-1633

H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003 Conference Report

Prescription Drug Benefit – Part D

- Drug benefit under new Part D begins Jan. 1, 2006. Standard benefit:
    - $250 deductible (increases by inflation each year based on Medicare drug expenditures)
    - 75/25 cost sharing (government/beneficiary) for drug costs up to $2250 (also increases by inflation each year)
    - Catastrophic benefit begins with out-of-pocket costs of $3600 (increases each year for inflation). Catastrophic copay of $2 for generics and $5 for other drugs along or 5% coinsurance (whichever is greater), annually indexed for Part D growth. Copay and coinsurance waived for low-income beneficiaries.
- Average premium monthly estimated at $35.
- Prescription drug plans (PDP) can differ from the standard benefit if providing actuarially equivalent coverage.
- Sponsors enter into a contract with the Secretary to provide PDP after submitting a bid that includes coverage provided, actuarial value, and premium amount. Two plans must be available in each region (established by the Secretary), including one drug-only plan. To ensure access to two plans, the Secretary may approve limited risk plans (federal government could assume up to 99.9% of risk) or may provide access a fallback plan where the Secretary pays actual costs of covered drugs.
- PDPs must provide access to negotiated drug prices and discounts and must disclose to the Secretary how these discounts are passed on to enrollees. A drug card is used to access the benefits (see Drug Discount Card below).
- Any willing pharmacy provider can participate. Plans may reduce co-pays for in-network pharmacies. Plans must have "sufficient" non-mail order pharmacies and "convenient access" to pharmacies (within 2 miles of most beneficiaries in urban areas, within 5 miles of most beneficiaries in suburban areas, and within 15 miles of most beneficiaries in rural areas). Beneficiaries would pay any difference in cost between mail order and a community pharmacy.
- Plans must have cost and utilization management program (including incentives to use generics), quality assurance measures, and systems to reduce errors (including an electronic prescription program).
- Plans could have tiered cost-sharing in a plan with a formulary and provide lower cost-sharing for "preferred drugs."

- Secretary must develop electronic prescription standards to be used by plan physicians and pharmacists. New standards will supercede conflicting state law and take effect in 2008. Authorizes $50 million in FY07 and such sums for FY08-09 for grants to physicians to implement electronic prescription programs.
- Low-income subsidies:
    - Below 135% of poverty – 100% premium subsidy, no deductible, no cost sharing.
    - Between 135% and 150% of poverty – income-related premium subsidy on a sliding scale from 100% subsidy to zero, $50 deductible, 15% coinsurance (rather than 25%), cost-sharing in catastrophic of $2 for a multiple source or generic drug and $5 for a non-preferred drug.
- Premium subsidies for all beneficiaries equal to 74%. Subsidy is paid to the plan sponsor through a combination of direct subsidy and reinsurance.
- Establishes risk corridors for plans. Plans with allowable costs above what was their target amount would receive increased payments and plans with costs below the target would receive reduced payments. Risk corridor is 2.5% for FY06-07 and 5% for FY08-11.
- Subsidies for employers who maintain employer-based coverage for retirees equal to 28% of drug costs between $250 and $5,000 (indexed annually based on growth in Part D costs). Employer-based coverage must provide coverage actuarially equivalent to the standard drug benefit. Subsidy payment is tax exempt.
- Medicare is primary payer for drugs, including for those seniors also eligible for Medicaid. Federal assumption of the costs of premiums and cost-sharing subsidies for dual eligibles (individuals eligible for both Medicaid and Medicare), currently paid through state Medicaid programs, would be phased in.
- Enrollees in a Medicare Advantage drug plan may only receive drug coverage through that plan.
- After January 1, 2006, no new MediGap policies may cover prescription drugs for Part D enrollees.
- Provides $62.5 million in mandatory funds each year for FY05 and FY06 for a State Pharmacy Assistance Program. Provides funding to states already operating drug financial assistance programs based on number of individuals served.

Drug Discount Card

- Administrator endorses at least two drug card programs that provide discounts.
- Transition program only until Part D benefits are available in 2006.
- Requirements of card plans:
    - Must pass discounts to beneficiaries
    - Cannot apply only to mail order pharmacies
    - Must provide support services and information to beneficiaries
    - Must have demonstrated experience, quality assurance procedures, and confidentiality protections
    - Must have an enrollment fee of $30 or less (enrollment fee paid by Secretary for beneficiaries below 135% of poverty)
- Assistance for low-income beneficiaries

    - Below 100% of poverty – government pays 95% of drug costs up to $600
    - Between 100% and 135% of poverty – government pays 90% of drug costs up to $600
- Authorizes "such sums" for the Administrator to oversee the programs.

Provisions Related to Drug Costs

- Makes changes to ensure faster approval of abbreviated drug applications for generic drugs.
- Makes changes related to patent extension through the Food and Drug Administration, including giving drug manufacturers only one opportunity to appeal the expiration of a brand-name patent and extend the patent for 30 months.
- Requires the Secretary to develop regulations that allow for the importation of drug from Canada into the U.S provided that the Secretary "demonstrates to the Congress that the implementation of this section will pose no additional risk to the public's health and safety" and will result in a significant reduction in the cost of prescription drugs to the consumer. The regulations must include the following requirements:
    - the drug must comply with FDA requirements, including provisions regarding safety and effectiveness.
    - the importer of the drug must comply with FDA requirements, including requirements that the importer provide documentation to the Secretary on the date the drug was shipped and in what quantity, certification that the drug is approved for use in the U.S., and laboratory records. The foreign seller must also provide a variety of documentation, including the original source of the drug and the quantity of drugs received.
    - the foreign seller must register with the Secretary.
    - importation on a drug would suspend "on discovery of a pattern of importation of that specific prescription drug or by that specific importer of drugs that are counterfeit or in violation of any requirement under this section, until an investigation is completed and the Secretary determines that the public is adequately protected from counterfeit and violative prescription drugs being imported."

Medicare Advantage (MA) – Part C

- New Part C includes Medicare + Choice.
- Payments equalized with FFS in 2004. After 2004, payments are increased annually by the percentage growth in Medicare per capita costs.
- Beginning in 2006, organizations submit bids against a benchmark each year based on average costs for a typical enrollee. The Secretary may reject bids or negotiate with plans.
- Plan sponsor receives drug subsidy payments and reimbursement for low-income premium and cost-sharing subsidies.
- Plans must provide the same premium for all enrollees.
- Enrollees choosing a plan with costs below the benchmark would get 75% of the savings. Enrollees choosing a plan with costs above the benchmark would pay the excess costs.

- Makes the Medicare MSA demo permanent and eliminates the cap on participation.
- 2-year moratorium on new local preferred provider organizations
- Allows for Medicare Advantage regional plans, with 10-50 regions. No limit on plans or bids in a region. Single deductible for Parts A and B.
- Risk corridors for Medicare Advantage plans, with increased payment if allowable costs over 103% of target amount and reduced payment if allowable costs below 97% of target.
- Stabilization fund of $10 billion between Jan. 1, 2007, and December 31, 2013, for Medicare Advantage to provide incentives to or retain plans. Bonus payments provided to nationwide MA plans.
- Increases the authorization for beneficiary education from $100 million to $200 million beginning in 2006.
- Enhanced MA payments for Federally Qualified Health Centers.

Comparative Cost Adjustment

- Demonstration project from Jan. 1, 2010, to December 31, 2015.
- To qualify for the demonstration, a Metropolitan Statistical Area (MSA) must have at least two local Medicare Advantage plans and 25% of beneficiaries enrolled in such plans.
- Up to six MSAs can take part in demo, with requirement that one MSA must be urban, one rural, and one mulitstate, with no more than two MSAs designated in the same region.
- Phased in over four years.
- Private plans would submit bids and traditional FFS would calculate FFS amounts, based on the adjusted average per capita cost in the area or region.
- Benchmark set at the weighted average of the private plan bids and the FFS amount in the area and phased in over four years.
- Enrollees choosing a plan with costs below the benchmark would get 75% of the savings. Enrollees choosing a plan with costs above the benchmark would pay the excess costs.
- Payment also based on demographic and health risks of enrollees.
- Change in Part B premium for traditional FFS enrollees in a demonstration area may not change more than 5%, with no premium change allowed for low-income beneficiaries.

Waste, Fraud, and Abuse Provisions

- Sets up "competitive acquisition areas" designated by the Secretary.
- Durable Medical Equipment – freeze on rates from 04-06. Phased-in competitive bidding beginning in 2007 (10 MSAs), expanding to 80 MSAs in 2009. Establishes quality standards and conditions for coverage.
- Increases practice expense reimbursement for the administration of outpatient drugs and biologicals. Secretary required to evaluate existing codes for drug administration and may adjust as necessary.

- Average Wholesale Price – Payment of 85% of AWP in 2004 (with some exceptions). The Secretary would have authority to increase or decrease reimbursement based on market surveys. AWP replaced by Average sales price (ASP) plus 6% beginning in 2005. Competitive bidding as a physician choice beginning in 2006.
- Three year demo program in 2 states (those with highest utilization rates) using recovery audit contractors to identify underpayments and overpayments and recoup overpayments.
- Pilot program for long-term care facility background checks. Provides $25 million for FY04-07.

Rural Health Package

- Disproportionate Share (DSH) formula for large urban hospitals applied to other hospitals, with a maximum adjustment of 12% (except for rural referral centers).
- Equalizes the standardized amount under the inpatient PPS for rural and urban hospitals.
- New essential rural hospital classification as part of the Critical Access Hospital program (high percentage of Medicare patients, adverse effect if closed).
- Critical Access Hospitals – payments based on 101% of costs.
- Two-year extension of the outpatient PPS hold harmless for small rural hospitals and sole community hospitals.
- Excludes certain rural health clinics and federally qualified health center services from Skilled Nursing Facility PPS.
- 5% home health payment increase for 2004.
- Ambulance payments based on the regional floor plus a 1% increase for urban areas and 2% increase for rural areas for two and a half years.
- 5% physician payment bonus in areas with few primary physicians or specialists for 2005-2007.
- Payment adjustment for low-volume hospitals beginning in 2005. Payment based on discharges and costs.
- Authorizes a Rural Hospice Demonstration Project and Rural Community Hospital Demonstration Program.
- Expands the telemedicine demonstration for four years and increases funding from $30 million to $60 million.
- Provides for the redistribution of unused Graduate Medical Education payments to small city and rural hospitals.

Provider Payment Adjustments – Part A and Part B

- Inpatient services payment for 2004-2007 of market basket minus, but provides for a reduction of 0.4% points if a provider fails to provide quality data to the Secretary. 2008 and beyond payment equals market basket with no exception.
- Home health payment for 2004-2006 of market basket minus 0.8% points.
- Provides coverage of hospice consultation services under Part A.
- Update of the single conversion factor for physicians in 2004 and 2005 of not less than 1.5% (instead of currently scheduled 4.5% reduction for 2004).

- Coverage under Part B for a beneficiary's initial physical, cholesterol and blood lipid screening once every two years, and annual diabetes screening. Waiver of Part B deductible for colorectal cancer screening tests.
- Outpatient drug payment for 2004-2005 cannot exceed 95% of the average wholesale price (AWP) or transition percentage (88-83% for sole source drugs, 68% for multisource drugs, 46% for generic drugs). After 2005, payment would be equal to the average price of the drug in the area as determined under the competitive acquisition program.
- Two-year moratorium on the $1500 outpatient therapy cap.
- Part B deductible increased to $110 in 2005. After 2005, the Part B deductible increases annually for inflation (based on overall Part B spending, the same process by which premiums are currently increased).
- New Chronic Care Improvement program. The Secretary awards contracts for programs in regions (also determined by the Secretary) to provide chronic care services to beneficiaries not enrolled in Part C (Medicare Advantage) or Part E (EFFS). Authorizes "such sums," but not more than $100 million over three years, for administration of the program. MA plans must also have chronic care improvement components.
- Increased Skilled Nursing Facilities payment of 128% for AIDS patients.
- Five-year freeze on laboratory payments.
- Specialty hospitals – 18-month moratorium on the self-referral whole hospital exemption, limitation on new beds added to existing hospitals of 5 or 50% of current beds (whichever is greater). Requires MedPAC and HHS studies of specialty hospitals.
- Suspends OASIS data collection requirement for home health until the Secretary issues regulations on the collection of non-Medicare/Medicaid information.
- Provides $250 million each year for FY05-08 for Emergency Medical Treatment and Active Labor Act (EMTALA) payments (for federally mandated emergency medical treatment of illegal aliens).
- Medicaid DSH – 116% payment for FY04, low DSH states receive 116% payment FY04-09.

Income Relation of Part B Premium

- Five-year phase-in of income relation of premium beginning in 2007. Premium subsidy would be as follows:
    - All beneficiaries under $80,000 (single) $160,000 couple continue to get 75% subsidy.
    - 65% premium subsidy for beneficiaries between $80,000 and $100,000.
    - 50% premium subsidy for beneficiaries between $100,000 and $150,000.
    - 35% premium subsidy for beneficiaries between $150,000 and $200,000.
    - 20% premium subsidy for beneficiaries over $200,000.

Cost Containment (as a matter of policy)

- The portion of Medicare spending coming from the general fund of the Treasury (i.e. from non-Medicare dedicated sources) is not supposed to exceed 45% of total

Medicare spending. This “cap” is permanent and would cover new benefits or expansions to existing benefits added by future Congresses.

- The Medicare Trustees will issue a report each year indicating whether or not during any of the next seven years the cap will be exceeded. If in two consecutive reports, the Trustees predict excess spending (i.e. above the cap), then the President is required to submit legislation to reduce the general fund portion of Medicare spending below the cap (i.e. reduce benefits or increase dedicated Medicare revenue – includes premiums and payroll taxes).
- If the House fails to vote on final passage of a bill to fix the problem by July 30, then 1/5 (88 Members) of the House can move to discharge a bill that fixes the problem. If the House votes (218 majority) to discharge the bill, the bill moves to the floor and there is an open rule (up to 10 hours for amendments) that waives all points of order against amendments (provided that if adopted the problem is still fixed).

Regulatory Reforms/Miscellaneous Provisions

- Establishes new center within the Centers for Medicare and Medicaid Services to oversee Part C (Medicare Advantage) and Part D (drug benefit).
- $1 billion for administrative expenses at CMS and $500 million for administrative expenses at the Social Security Administration.
- No retroactive application of substantive changes.
- Requires “fair and early” presentation of evidence for Medicare appeals.
- Allows the Secretary to contract with “Medicare administrative contractors for certain functions like making payments, beneficiary assistance, consultation services, and provider education starting October 1, 2005. Competitive bidding for such services would begin in 2011.
- Such sums for provider education.
- Such sums for small provider technical assistance demo.
- $3 million for Citizens Health Care Working Group
- $50 million for research on health care outcomes
- $200 million for Health Care Infrastructure Improvement Program
- Requires the Secretary to appoint a Medicare Beneficiary Ombudsman.
- Beneficiary outreach demo through Social Security Agency offices.
- Transfers Medicare appeals from SSA to HHS.
- Establishes process for expedited judicial review for providers.
- The Secretary can enter into repayment plans with providers if returning an overpayment is a hardship.
- Establishes an overutilization process for the Secretary to provide notice to providers if certain billing codes are being overutilized.
- Requires the Secretary to establish a process for providers to correct minor claims errors.
- Authorizes dozens of studies and reports by HHS, the HHS Inspector General, the General Accounting Office, and MedPAC.

Health Savings Accounts

- Allows workers under age 65 to save in tax-free accounts, with withdrawals for qualified health care expenses also tax-free. Qualified expenses include:
  - Amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease,
  - Prescription drugs,
  - Qualified long-term care services and long-term care insurance,
  - Continuation coverage required by Federal law (i.e., COBRA),
  - Health insurance for the unemployed,
  - Medicare expenses (but not Medigap), and
  - Retiree health expenses for individuals age 65 and older (Note: retiree health plans would not have to meet the $1,000/$2,000 minimum deductible requirements.)
- Distributions made for any other purpose are subject to income tax and a 10% penalty. The 10% penalty is waived in the case of death or disability. The 10% penalty is also waived for distributions made by individuals age 65 and older.
- Worker must also be enrolled in a "qualified health plan" with a minimum deductible of $1,000 with a $5,000 cap on out-of-pocket expenses for self-only policies (amounts doubled for family policies).
- Individuals can make pre-tax contributions of up to 100% of the health plan deductible. The maximum annual contribution is $2,600 for individuals with self-only policies and $5,150 for families (indexed annually for inflation).
- Catch up contributions are allowed for those over age 55, starting with $500 in 2004 and increasing to $1000 in 2009.
- Individuals, family members and employers may make contributions.

CBO Cost Estimate: CBO estimates that the bill will increase mandatory spending $395 billion over the 2004-2013 period. An estimate is not available on the bill's impact on discretionary spending or on possible reductions in employer-sponsored coverage (a previous CBO estimate of the House-passed version of H.R. 1 estimated that 32 percent of current retirees with employer-sponsored coverage would have that coverage replaced. However, CBO is expected to revise this estimate, taking into account union contacts, which will reduce this number). The complete estimate can be found here - ftp://ftp.cbo.gov/48xx/doc4808/11-20-MedicareLetter.pdf

RSC Contact: Lisa Bos, 6-1630, lisa.bos@mail.house.gov