Summary of Medicare Conference Agreement

This document is an outline of resolutions to the major issues in the Medicare prescription drug and modernization bill. It does not include issues ratified by Members in the July and September bicameral-bipartisan meetings.

Rx Drug Discount Card

- Medicare-endorsed prescription drug discount cards would be available to all Medicare beneficiaries April 2004.
- HHS estimates savings between 15% and 25% per prescription
- Low-income beneficiaries receive $600 of assistance per year for 2004 and 2005.

Prescription drug benefit

Standard Benefit in 2006

- $275 deductible
- 75-25 coverage to $2,200
- $3,600 out-of-pocket catastrophic coverage, (Low-income below 135% of poverty have no copayments above catastrophic, between 135-150% $2/$5 copayments. Above 150% of poverty 5% coinsurance.)
- Risk corridors (plans at risk for 50% of costs above 2.5% of bid; 80% above 5%.)
- $35 average premium

Government Guarantee:

- Beneficiary access to at least one Prescription Drug Plan (PDP) and one integrated plan in each region. Two PDPs are required if no integrated plan is available.
- Bids for risk-plans and reduced risk plans must be submitted concurrently. If risk plans meet specified conditions and are accepted by the Secretary, the Secretary will not accept reduced risk or fallback plans.
- If no risk plans or fall back plans bid in a region, the fall back plan would provide coverage in that area. Fall back plans must offer the standard benefit, accept performance risk, and its premiums are set by Medicare.

Low-income Assistance

- Duals have access to Medicare benefit;
  - Federal rules apply throughout benefit
  - 10 year phase-down to 75% state contribution, 75% applies thereafter
- Cost-sharing and premium assistance for those up to 150% of poverty with no gap in coverage
- For dual eligible with incomes below 100% of poverty $1 for generics and $3 for brand name.

- Up to $2 copays for generics drugs and up to $5 copayment for brand name/and non-preferred drugs (indexed) for all other low-income beneficiaries under 135% of poverty. . Medicaid can provide coverage for classes of drugs not covered by Medicare (e.g. prescribed over-the-counter, benzodiazepines etc.)
- House asset test ($6,000/$9,000 and indexed to inflation) for those below 135% of poverty
- Below 150% of the FPL -- $50 deductible and a sliding scale premium; 15% coinsurance up to the catastrophic limit; $2-$5 copayments thereafter. Asset test ($10,000/$20,000 single/couple indexed to inflation)

Retiree Coverage

- Retiree plans offering actuarially equivalent coverage receive 28 percent payment for the drug costs between $250 and $5,000. The subsidy for retiree prescription drug coverage is excludable from taxation.
- Qualified retiree plans have maximum flexibility on plan design, formularies and networks.
- Employers can also provide premium subsidies and cost-sharing assistance for retirees that enroll in a Medicare prescription drug plans and integrated plans.
- Employers can negotiate preferential premiums from integrated plans.

Private Plans and Competition

- Add new payment option of 100% of fee-for-service in 2004, and increase all rates by growth in FFS Medicare thereafter.
- Local and regional plans bid in 2006 with 75-25 split on savings for those bidding below the benchmark.
- Regional plans operate under same rules as local plans, except:
    - Blended benchmark, where private plan bids can affect the benchmark in proportion to their national market share.
    - Incentives on network adequacy.
    - Risk corridors: 3%/8% corridors on benefits under Parts A and B.
    - Stabilization fund for plan entry and retention.
- Comparative cost adjustment program
    - Begin in 2010 in up to 6 Metropolitan Statistical Areas (MSAs) for 6 years.
    - Demonstration sites chosen from MSAs with 2 local private plans with at least 25% total local private plan penetration. (Beneficiaries in counties within a triggered MSA that lack at least 2 private plans would not be affected).
    - Part B premiums for beneficiaries remaining in traditional fee-for-service (FFS) program could not go up or down by more than 5% in any year as a result of the demonstration.
    - Beneficiaries with incomes below 150% of poverty, and assets as under Title I, would be protected from any Part B premium change as a result of the benchmark.
    - Continued entitlement to defined benefits for all beneficiaries.

  - All plans, including the traditional FFS plan, would be paid based on the demographic and health risks of enrollees. If traditional FFS plan disproportionately enrolls beneficiaries with poor risk, beneficiary premium changes would be adjusted to compensate.
  - To compute the benchmark in competitive areas, the national FFS market share would be used even in areas where the local FFS market share is lower.

Rural Package

The largest, most comprehensive rural package ever considered by Congress. All significant provisions in both bills including:

- Standardized amount continues without pause, April 2004.
- Medicare DSH for rural and small urban hospitals would be increased to 12% cap in 2004.
- Labor share at 62% would start in 2005.
- Low volume hospitals: Number of discharges is 800. Payment adjustment is based on empirical relationship between discharges and costs. Must meet 25 mile limitation.
- Redistribution of unused graduate medical education payments to rural hospitals and small city hospitals.

Hospitals

- The hospital update would be set at market basket (current law) for FY2004. However, payments would be reduced by 0.4 percent in FY 2005, FY 2006, or 2007 if the hospital did not furnish quality data to CMS. No effect on baseline.
  - Hospitals would submit data to CMS for a specified set of indicators related to the quality of care provided to Medicare patients. The indicators would build on CMS' experience with the ongoing Hospital Quality Incentive Data initiative being conducted with the major hospital trade groups.

- IME: 6.0 for last half of FY2004, 5.8 in FY 2005, 5.55 in FY2006, 5.35 in FY2007.

- Specialty Hospitals: There would be an 18 month moratorium of the self-referral whole hospital exemption for new specialty hospitals. "New hospitals" do not include existing hospitals or those under construction as specified in the S.1, effective the day the House files the bill. Existing hospitals can add up the greater of 5 beds or 50% of the beds on their current campus. During the moratorium period, MedPAC would conduct an analysis of the costs of the specialty hospitals and whether the payment system should be refined. The Secretary would examine referral patterns and quality of care issues.

- Technology integration package at $600 million.. Improvements on national and local coverage policy and expansion of clinical trials.

- Illegal immigrants: $1 billion mandatory spending for hospitals, ambulances and physicians providing services under an EMTALA related admission.

Physicians

- The 4.5% cut in 2004 and additional cut in 2005 would be blocked. Instead, physicians would receive a 1.5 percent update in 2004 and 2005.
- 1.0 on work geographic payment adjuster(GPCI) in 2004 through 2006.
- Physician scarcity bonus payment 2005-2007.

Home Health

- No copayment,.
- MB –0.8 for 2004-06. Continue current outlier policy of allocating no more than 3% for outliers
- 5% rural bonus payment for one year

Other

- Durable medical equipment rates will be frozen for three years from 04-06. The rates for the top 5 services will be adjusted to reflect prices paid under the FEHBP plans. Competitive bidding for the largest MSAs begins in 2007 phasing up to 80 MSAs in 2009. Competitive bidding prices applied nationwide for those selected services.

- Ambulance payments based on the regional floor and the adjustment for low population rural areas plus a 1 percent across the board for urban areas and 2% across the board for rural areas for two and a half years.

- Community health centers safe harbor is included. Carve-out of community health center physicians from the skilled nursing facility PPS. Federally Qualified Health Centers would receive wrap-around payment if MA plans pay less than FQHC costs.

- 7 year freeze on laboratory payments.

Beneficiary Issues

- Provide initial voluntary physical when becoming eligible for Medicare.

- Cover new preventive benefits: screening for diabetes and cardiovascular disease.

- Improve payments for mammography.

- Part B deductible at $110 in 2005 and indexed to growth in Part B expenditures.

- Provide a disease management program to assist beneficiaries with chronic illnesses.

Average Wholesale Price (AWP) Reform

- AWP minus 15% in 2004.
  - The Secretary would have authority to increase or decrease reimbursement based on market surveys.
- Average sales price (ASP) plus an additional percentage beginning in 2005.
- Competitive bidding as a physician choice beginning in 2006.
- Secretary has the authority to adjust reimbursement for a drug, where the ASP is found to not reflect widely available market prices.
- Manufacturers would be required to report ASP data. Manufacturer reporting of false ASP information would be a violation of the False Claims Act.
- The HHS Inspector General would be required to regularly audit manufacturer submitted ASPs and compare them with widely available market prices and Medicaid Average Manufacturer Prices (AMP).
- Increase practice expense reimbursements for drug administration
  - Examine existing codes for drug administration and exempt any revisions from budget neutrality requirement.
  - Allow for supplemental surveys on practice expenses for drug administration, and exempt any resulting changes from budget neutrality.
  - Require MedPAC review of payment changes as they affect payment and access to care by January 2005 for oncologists, and by January 2006 for other affected specialties.

Income-Relate Part B Premium

- Income thresholds:
  - 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

- Five year phase-in of new premiums beginning in 2007.
- Income levels doubled for married couples.
- Permit beneficiaries to appeal if their family situation has changed (e.g., death of spouse, divorce).

Cost Containment

- Transparency in accounting for entire Medicare program.
- Mechanism to require congressional response of the Medicare program if general revenue contributions exceed 45% of program spending.

Medicaid

- House DSH policy modified so that the first year increase is 16 percent in 2004
- Low DSH states will get a 16 percent annual bump up for five years.

Tax Provisions

- Clarify that employers do not have to provide 1099 Forms to service providers if services are paid for with a debit, credit or stored-value card.
- Create tax-free Health Savings Accounts (HSAs) for qualified medical expenses.
- The 28 percent employer subsidy for retiree prescription drug coverage is excludable.

Hatch-Waxman reforms

The Conference Agreement ends existing loopholes in the Hatch-Waxman law by making changes to the 30 month stay and 180 day provisions. Under the conference agreement, new drug applicants will receive only one 30 month stay per product for patents submitted prior to the filing of a generic drug application. In addition, the Conference agreement modifies rules relating to generic company's 180 day exclusivity. Specifically, it enables multiple companies to qualify for the 180 day exclusivity if they all file their application on their first day of eligibility. Additionally, the conference agreement will contain provisions relating to declaratory judgments which are designed to accelerate generic company's ability to enter the marketplace.

Reimportation

Canada only with safety certifications. In addition to a study by the Secretary on the major safety and trade issues regarding reimportation.