Grassley-Baucus Medicare Proposal
(subject to revision pending CBO scores)

Drug Benefit

Basic Framework. The proposal establishes a voluntary drug benefit under Medicare Part D. The benefit would be integrated with other medical benefits for those who enroll in a private managed care or preferred provider plan. For beneficiaries who stay in fee-for-service, the benefit would be provided through stand-alone drug only plans. The value of, and subsidy toward, the drug benefit for beneficiaries in private plans and FFS would be equal.

Drug Benefit Structure. Beginning January 1, 2006, the new benefit would be structured as follows:

- $275 deductible
- $35 monthly premium (estimate; not set in law)
- 50% coinsurance from $276 to $3450
- 100% beneficiary coinsurance from $3451 to $3700 stoploss
- 10% beneficiary coinsurance above the stoploss

True Out of Pocket (TROOP) definition of stoploss would apply: only contributions by the beneficiary, the beneficiary's family, Medicaid, and State Pharmacy Assistance Programs will count toward the stoploss. Note that this means the stoploss will be a minimum of $5288; if a beneficiary has another source of drug coverage (eg employer retiree plan), he or she might not hit the stoploss until $10,000 or more in total drug costs.

Low Income Assistance. Special help will be provided to seniors with incomes less than or equal to 150% of the federal poverty level (FPL) (34% of all seniors). These subsidies are available at increasing levels of generosity for three categories of seniors: those with incomes below 100% of the FPL; those between 100% and 135% of the FPL; and those between 135% and 150% of the FPL (see below). Dual eligibles (those eligible for both Medicaid and Medicare) will continue to get their drug benefits through Medicaid.

Seniors with incomes below 100% of FPL and who meet the QMB assets test

- no deductible and no premium
- 2.5% beneficiary coinsurance from $276 to $3450
- 5% coinsurance from $3450 to stoploss ($3700 TROOP)
- 2.5% coinsurance above stoploss

Seniors with incomes between 100% and 135% of FPL with SLMB/QI-1 assets test

- no deductible and no premium
- 5% beneficiary coinsurance from $276 to $3450
- 10% coinsurance from $3450 to stoploss ($3700 TROOP)
- 2.5% coinsurance above stoploss

Seniors with incomes between 135% and 150% of FPL

- $50 deductible
- sliding scale premium (0 at 135% of FPL to $35 at 150% FPL)
- 10% beneficiary coinsurance from $276 to $3450
- 20% coinsurance from $3450 to stoploss ($3700 TROOP)
- 10% coinsurance above stoploss

Interim drug discount card. Drug discount cards will be available on an interim basis until January 1, 2006. QMBs, SLMBs and QI-1s will get $600 a year on the card in 2004 and 2005. Drug discount cards are estimated to provide small subsidies off of retail pharmacy prices, but it is not clear how big these discounts would be in practice.

Drug Delivery Model

Phased in Risk. Insurers would bear partial risk, moderated through reinsurance and risk corridors. In 2006 and 2007, insurers would bear a smaller portion of risk in the hope that this will lure them into the system.

Fallback. A fallback will be available in areas where fewer than 2 private plans offer a drug benefit. Fallback plans would be required to offer the standard drug benefit and a national premium.

PPOs and Private Plan Competition

Medicare Advantage. The proposal restyles Medicare + Choice as a new Medicare Advantage program for beneficiaries in private plans. The current law Medicare + Choice program would be modified to enable PPOs to offer health plans on a regional basis. Traditional HMOs would be permitted to offer plans on a county-by-county basis.

Any beneficiary enrolled in Parts A, B, and D can enroll in a regional PPO or local HMO if one is available in his/her area.

Benefits Levels. All health plans would be required to offer at least the standard drug benefit (or its equivalent in actuarial value). Plans would be required to offer catastrophic benefits for traditional Medicare medical benefits (however, the federal contribution would not reflect this requirement), and encouraged to offer disease management, chronic care and quality improvement programs.

The bill would improve the current payment structure for private health plans. Both PPOs and HMOs would be paid on a competitive bidding process rather than through a statutory formula. (The FFS program would not be included in this bidding process.)

Benchmark. The Federal contribution to plans would be capped to ensure that the payment level is no higher than local FFS costs (or the current law HMO rate, whichever is higher). Growth in the current law floor payment rates would be limited to growth in the CPI starting in 2006.

Payment to PPOs. To encourage the participation by PPOs, these plans would receive an additional payment of 2% for the first five years of the new program.

Beneficiary Premiums. Beneficiaries would pay lower premiums for plans that bid below benchmark and higher premiums for plans that bid above the benchmark. The government shares the savings (25% to government; 75% to beneficiary) if a beneficiary chooses a lower cost plan.

For the drug benefit, health plans would be paid under the same methodology and qualify for risk-sharing as drug only plans offered to FFS enrollees.

Consumer protections that exist under current law for beneficiaries who return to FFS under Medicare + Choice would remain in place under Medicare Advantage.

Medicap options remain largely unchanged, except that Plans H,I and J would be dropped (though existing participants in these plans could be grandfathered in).

Fee For Service Modernization

Chronic Care Demonstration Project. The proposal includes a chronic care demonstration project to evaluate payment methods for and effectiveness of geriatric assessment and care coordination for beneficiaries with multiple chronic conditions and special needs. (Based on Lincoln bill; available in 6 states, one of which must be Arkansas.)

Rural Equity (based on Grassley amendment to the tax bill)

- Equalize standardized amount
- equalize Medicare DSH
- low volume adjuter
- decrease hospital labor related share to 62%
- hold harmless for rural HOPD extended for 2 years
- Improve CAH (per Grassley amendment)
- Home health add-on reduced to 5% and extended 2 years
- 5% clinic and emergency room add-on extended 2 years
- Rural ambulance 5% add-on for ground trips extended 2 years
- Air ambulance rate fix (from S. 3018)
- SNF consolidated billing
- Medicare incentive payments of 10% made automatic in HPSAs
- SCH lab tests paid on a cost basis for 2 years
- GPCI floors for physician work increased to 1.0 and for practice expense and liability insurance increased over 10 years
- RHC clinic capped payment increased to $79
- composite payment for ESRD increased by 1.6% for 2 years
- extend special treatment for certain pathology services
- demonstration project for chiropractic services
- Medicaid DSH – DSH standard raised for low-DSH states for 2 years and DSH cliff restored for 1 year

Medicare Appeals, Regulatory, and Contracting Improvements (MARCIA) (based on S. 3018)

Process. MARCIA would require CMS to revises practices relating to promulgation and enforcement of new Medicare regulations and require Secretary to report on legal and regulatory inconsistencies in the Medicare program.

Appeals Process Reform. CMS must submit a detailed plan to Congress regarding transfer of the Medicare appeals function from SSA to HHS. CMS must also expedite some kinds of appeals and allow immediate access to judicial review for others.

Local Coverage Decisions. The proposal would allow providers to appeal or seek review of local coverage decisions.

Contractor Reform. The proposal would authorize CMS to competitively bid for the Medicare contractor function. 6 year contract cycle.

Education and Outreach Improvements. The proposal would require contractors to provide more education and technical assistance to providers. There would be a new ombudsmans office for beneficiaries and providers. The plan would protect providers from penalties if they relied on incorrect guidance from a contractor.

Review, Recovery and Enforcement. The proposal would standardize procedures for pre-payment reviews of provider claim; standardize policies for CMS's recovery of overpayment from providers; and allow providers to correct minor errors and omissions for a rejected claim and resubmit them without having to file an appeal.

Offsets

DME The proposal would implement a 7 year freeze on DME payments.

AWP. Payment would be reduced to 85% of AWP (practice expense for oncologists and other affected providers would also be adjusted).

Cost sharing for lab services performed in doctor's offices and HOPD (no copayments for charges under $40)

Custom User Fees

New Agency

The proposal creates a new agency at HHS to administer Medicare Part C and Medicare Part D. CMS would continue to administer FFS Medicare, Medicaid and SCHIP. The new agency would centralize bidding and private plan administration.