A Comparison of the Medicare Prescription Drug Conference Agreement with the House and Senate Passed Bills

ISSUES	HOUSE BILL– H.R. 1	SENATE BILL– S. 1	CONFERENCE AGMT
Standard Drug Benefit	Premium -- $420 average yearly Deductible -- $250 yearly Cost Sharing -- $350 = 20% of costs between $250 and $2000 Donut Hole -- $2,900 = 100% of costs between $2,000 and $4,900 Catastrophic Coverage -- full coverage after beneficiary spends $3,500 out of pocket	Premium -- $420 average yearly Deductible -- $275 yearly Cost Sharing -- $2,112 = 50% of costs between $275 and $4,500 Donut Hole -- $1,313 = 100% of costs between $4,500 and $5,813 Catastrophic Coverage -- 10% after beneficiary spends $3,700 out of pocket	Premium -- $420 average yearly Deductible -- $250 yearly Cost Sharing -- $500 = 25% of costs between $250 and $2,250 Donut Hole -- $2,850 = 100% of costs between $2,250 and $5,100 Catastrophic Coverage – Greater of $2 or $5 copayments or 5% coinsurance after beneficiary spends $3,600 out of pocket
Coverage Gap / "Donut Hole"	Gap of $2,900.	Gap of $1,313.	Gap of $2,850 -- More than two times the Senate coverage gap, and the gap increases to over $5,000 by year 2013.
Fallback Plan	No government fallback plan. Government pays money to plans until two plans available for beneficiaries.	Government fallback available when less than two private drug plans available in a region.	Government fallback available when less than one private drug plan and one PPO available in a region. One half the number of people would get fallback protection as compared to the Senate bill.
Low Income Protections	Full premium subsidy and minimal cost sharing protections for those making less than 135% FPL and sliding scale premium subsidy for those making less than 150% FPL. No coverage in donut hole. To qualify beneficiary assets must be under $6,000 an individual or $9,000 a couple with some asset exemptions. Copays amounts increased by the cost of drugs over time.	Full premium/deductible subsidies and cost sharing protections for those making less than 135% FPL including through donut hole and catastrophic threshold. To qualify, beneficiary assets must be under $6,000/ individual or $9,000/couple before 2009 and under $10,000/$20,000 after 2009 with some asset exemptions. Sliding scale premium subsidy, partial deductible subsidy, and minimal cost sharing protections for those making less than 160% FPL, including through donut hole, with no qualifying assets test.	For <100% FPL there are full premium/ deductible subsidies and $1 and $3 copays for those with assets under $6,000/ individual or $9,000/couple through coverage gap. Full catastrophic coverage. For <135% FPL there are full premium/ deductible subsidies and $2 and $5 copays for those with assets under $6,000/ individual or $9,000/couple through coverage gap. Full catastrophic coverage. For <150% FPL there is a sliding scale premium, $50 deductible and 15% copays through donut hole. There are $2 and $5 copays after the catastrophic threshold is reached. To qualify beneficiary assets must be under $10,000/ individual or $20,000/couple. For institutionalized dual eligibles no copayments regardless of income or assets through coverage gap. Full catastrophic coverage. Deductible amounts increased by the cost of drugs over time. 3.9 million fewer people would be qualified for low income protection as compared to the Senate bill because there is NO assistance for those making between 150% and 160% FPL and there is a more restrictive asset test to qualify than the Senate bill.
Medicaid Coordination with Medicare	States maintain "wrap around" coverage required under current law for dual eligibles with Medicare as primary payor and Medicaid as secondary payor. However, Medicaid is not permitted to receive the federal matching rate to cover the cost sharing differences between Medicare and Medicaid.	States maintain levels of coverage required under current law for dual eligibles through Medicaid.	6.4 million low-income and disabled people would have significantly worse coverage then they currently have – these dual eligibles will be covered by Medicare, but Medicaid will not be permitted to receive the federal matching rate to cover the cost sharing differences between Medicare and Medicaid and it will not be permitted to provide "wrap around" coverage for medically needy medications in a Medicare therapeutic class that Medicare does not cover.

State Required Payments for Low-Income Beneficiaries	States currently responsible for the cost of drugs for low-income Medicare beneficiaries, but responsibility would shift to the federal government over 15 years.	Not applicable.	States would be responsible to pay the Federal Government 90% of the cost of drugs for low-income Medicare beneficiaries phasing down to 75% in perpetuity.
Support for HMOs and PPOs	Increased payments to managed care plans as a percentage of FFS in addition to the current 119% of FFS payments they receive (MEDPAC/CMS data).	Increased payments to managed care plans as a percentage of FFS in addition to the current 119% of FFS payments they receive (MEDPAC data) + $6 billion to managed care plans in incentive/stabilization payments.	Combines both bills – Increases payments to managed care plans to 125% in 2006 in addition to the current 119% of FFS payments they receive (MEDPAC/CMS data) similar to the House bill, and doubles the Senate's incentive and stabilization payments to $12 billion for a total of $17 to $20 billion for managed care plans.
Privatizing Medicare	Premium support/voucher program in 2010 that would result in higher and varied premiums across the country.	No such provision.	Premium support/voucher proposal beginning in 2010 for six years that would result in higher and varied Part B premiums in six metropolitan statistical areas (MSAs) around the country where there is 25% local private plan penetration rate. 41 MSAs are eligible to be exposed to uncertain, higher, and variable Part B premiums that will be determined by HMOs and PPOs. Taking six MSAs that may qualify in 2010, up to 6.8 million people could be affected.
Income Relating to Part B Premium	No such provision.	No such provision.	Higher Part B premiums for the same level of coverage for individuals with incomes above $80,000 an individual or $160,000 a couple, beginning in 2007.
Part B Deductible Increase	Current Part B deductible, $100, indexed to grow by the annual percentage increase of the Part B premium starting in 2004.	Increased from $100 to $125 for 2006 and 2007. Indexed to grow by the CPI for each year thereafter.	Increased from $100 to $110 in 2005. Indexed to grow by the annual percentage increase of the Part B premium starting in 2006.
Loss of Employer Sponsored Retiree Coverage	CBO estimates that 3.8 million seniors or 32% of the approximately 12 million seniors that currently have employer sponsored retiree coverage will lose that coverage.	CBO estimates that 4.3 million seniors or 37% of the approximately 12 million seniors that currently have employer sponsored retiree coverage will lose that coverage.	Approximately two to three million of the 12 million seniors that currently have employer sponsored retiree coverage will lose that coverage.
Health Savings Accounts	No such provision in H.R. 1, but $5.6 billion in health tax shelters rolled into H.R. 1 through a separate bill.	No such provision.	Expands House provision to $6.7 billion in health tax shelters.
Creating an Artificial Medicare Solvency Crisis	No such provision.	No such provision.	When general revenue spending in Medicare reaches 45% of the total Medicare spending, requires consideration of legislation to limit Medicare funding, meaning providers and beneficiaries could face cuts.
Drug Prices	The Secretary of HHS is prohibited from negotiating lower drug prices using the force of the 40 million Medicare beneficiaries.	The Secretary of HHS is prohibited from negotiating lower drug prices using the force of the 40 million Medicare beneficiaries.	The Secretary of HHS is prohibited from negotiating lower drug prices using the force of the 40 million Medicare beneficiaries.
Importation of Drugs	Importation permitted from Canada only, and only if HHS Secretary certifies that no safety risk exists. But House Republican Leadership agreed that H.R. 2427 would be the House negotiating position. H.R. 2427 permits importation from 25 countries if the manufacturing, processing, and shipping meet standards set by the FDA. H.R. 2427 does not require HHS Secretary to certify that no safety risk exists.	Importation permitted from Canada only, and only if HHS Secretary certifies that no safety risk exists. Bars discrimination between countries on terms and condition of sale.	Importation permitted only from Canada and only if HHS Secretary certifies that no safety risk exists.