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Overview of the Medicare Prescription Drug and Reform Legislation

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Medicare Prescription Drug and Reform Legislation

Summary

On June 27, 2003, the Senate passed the Prescription Drug and Medicare Improvement Act of 2003, S. 1, by a vote of 76-21. Later that same evening, the House passed the Medicare Modernization and Prescription Drug Act of 2003, H. R. 1, by a recorded vote of 216-215 with one voting present. Generally, the bills create a prescription drug benefit for Medicare beneficiaries and establish a new MedicareAdvantage program (Medicare Advantage program in the House bill) to replace the current Medicare+Choice program. The new drug benefits, the new Advantage program, and other beneficiary functions would be administered by a new agency created under both bills. Both bills would also establish a number of provider payment adjustments, beneficiary cost-sharing adjustments, and change certain regulatory practices. Significant differences between the bills need to be resolved before legislation can be enacted.

To that end, the 17-member House-Senate Medicare conference met July 15, 2003 to develop a process to reconcile the differences between the two bills. On July 24, 2003, the conferees came to a tentative agreement on the contracting and regulatory relief provisions in the Medicare reform legislation. During that meeting, conferees established a schedule for the Congressional staff working for the lawmakers serving on the conference to continue negotiations during the August recess and into September. On August 5, 2003, a tentative agreement regarding the provisions concerning a drug discount card was announced. Congressional staff will now turn to resolving differences in provisions concerning noncontroversial provider issues and additional fee-for-service benefits.

The Congressional Budget Office (CBO) has estimated that spending under S.1 would increase direct (or mandatory) spending by $421 billion over the FY 2004 - FY 2013 period, without a provision requiring pharmacy benefit managers to disclose certain information or $461 billion including that provision. CBO also estimates that provisions of S.1 that would be subject to the appropriations process would cost $4 billion over the 10-year period, assuming appropriations of the necessary amounts. H.R. 1 is estimated as increasing direct spending by $405 billion over the FY2004 - FY2013 period and, assuming appropriation of the necessary amounts, as increasing spending subject to appropriation by $14 billion over the 10-year period.

This report is an overview of the major features of the Medicare and Medicaid provisions of S. 1 and H.R. 1. and will be updated to reflect legislative activity. For more detailed discussions of the specific Medicare and Medicaid provisions of both bills, see CRS Report RL31992, *Medicare Prescription Drug Provisions*; CRS Report RL32005, *Medicare Fee-for-Service Modifications and Medicaid Provisions*; and CRS Report RL30901, *Regulatory Reform Provisions*,. For information on the new agency provisions of the bills, see CRS Report RL32029, *New Medicare Agency Provisions of S. 1, as Passed by the Senate, and H.R. 1, as Passed by the House*. The bills also contain provisions beyond Medicare and Medicaid. For information on the Hatch-Waxman provisions, see CRS Report RL32003, *Hatch-Waxman Related Provisions*. For information on the health savings accounts provisions in H.R. 1, see CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses*.

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Medicare Prescription Drug and Reform Legislation

The Senate and House are conferencing legislation to add a prescription drug benefit to Medicare and reform a number of aspects of the program. On June 27, 2003, the Senate passed S. 1, the Prescription Drug and Medicare Improvement Act of 2003, by a vote of 76-21. Later that same evening, the House passed H. R. 1, the Medicare Modernization and Prescription Drug Act of 2003, by a recorded vote of 216-215 with one voting present.

The bills contain a similar structure in that both add a prescription drug benefit and replace the existing Medicare+Choice program with a new program that establishes payments based on a system of bids and benchmarks. Both bills would create a new agency within the Department of Health and Human Services (HHS) to administer the prescription drug benefit and the new MedicareAdvantage program. Both bills also contain numerous provisions that would generally increase fee-for-service Medicare payments, especially for rural health care providers, and would modify numerous regulatory and administrative practices.

Despite the similar overall structure, there are significant differences between the Senate and House bills. To that end, the 17-member House-Senate Medicare conference met July 15, 2003 to develop a process to reconcile the differences between the two bills.[1] On July 24, 2003, the conference came to an agreement on the contracting and regulatory relief provisions in the Medicare reform legislation.[2] During that meeting, conferees established a schedule for the Congressional staff working for the lawmakers serving on the conference to continue to negotiations during the August recess and into September.[3] On August 5, 2003, a tentative agreement regarding the provisions concerning a drug discount card was announced.[4] Congressional staff will now turn to resolving differences in provisions concerning noncontroversial provider issues and additional fee-for-service benefits. These

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[1] The Senate members who were appointed as conferees include: Mr. Grassley, Mr. Hatch, Mr. Nickles, Mr. Frist, Mr. Kyl, Mr. Baucus, Mr. Rockefeller, Mr. Daschle, and Mr. Breaux. The House members who were appointed as conferees include: Mr. Thomas, (who will chair the conference), Mr. Tauzin, Mrs. Johnson, Mr. Bilirakis, Mr. DeLay, Mr. Dingell, Mr. Rangel, and Mr. Berry.

[2] See [http://waysandmeans.house.gov/media/pdf/healthdocs/regreform.pdf] and [http://waysandmeans.house.gov/media/pdf/healthdocs/regreformagreement.pdf] for additional information regarding the agreement.

[3] See [http://waysandmeans.house.gov/media/pdf/healthdocs/calendar.pdf] for announced schedule.

[4] See [http://waysandmeans.house.gov/News.asp?FormMode=print&ID=109] for an announcement regarding the tentative agreement regarding the drug discount card program.

announced agreements are considered to be indicative of the final outcome regarding any specific provision but may be subject to change, given the entire shape of the negotiated bill.

The cost of the legislation is likely to play an important role in the conference agreement. The budget reconciliation agreement created a reserve fund of $400 billion over 10 years for Medicare modernization, creation of a prescription drug benefit, and, in the Senate, to promote geographic equity payment. Some conferees, including Senate Finance Committee Chairman Grassley, House Ways and Means Committee Chairman Thomas, and House Energy and Commerce Committee Chairman Tauzin, have announced their intent to meet the $400 billion target. However, the Congressional Budget Office (CBO) has estimated the cost of both S.1. and H.R.1 as slightly above that target. CBO estimates that direct (or mandatory) spending under S.1. would increase by $421 billion over the FY 2004 - FY 2013 period, without a provision requiring pharmacy benefit managers to disclose certain information or $461 billion including that provision. CBO also estimates that provisions of S.1 that would be subject to the appropriations process would cost $4 billion over the 10-year period, assuming appropriations of the necessary amounts. H.R. 1 is estimated as increasing direct spending by $405 billion over the FY2004 - FY2013 period and, assuming appropriation of the necessary amounts, as increasing spending subject to appropriation by $14 billion over the 10-year period.[5]

Prescription Drugs[6]

Senate

Title I of the Senate bill would establish a new outpatient prescription drug benefit under a new Medicare Part D, effective January 1, 2006. The bill would rely on private plans to provide coverage and to bear a portion of the financial risk for drug costs; federal subsidies would be provided. In general, MedicareAdvantage enrollees would obtain drug benefits through their MedicareAdvantage plan. Other Part D enrollees would receive their drug coverage through enrollment in a Medicare Prescription Drug Plan offered in the geographic area in which the beneficiary resides. Persons currently receiving drug coverage through Medicaid would not be eligible for Part D. Other persons with incomes below 160% of poverty would be eligible for low-income subsidies. The program would be administered by the Administrator of the new Center for Medicare Choices.

Beneficiaries eligible on November 1, 2005, would have a 6-month open enrollment period. Persons becoming eligible after that date would have a 7-month initial enrollment period. Persons enrolling in Part D after their initial enrollment period would be subject to delayed enrollment penalties. However, if they had

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[5] See [http://www.cbo.gov/showdoc.cfm?index=4438&sequence=0] for cost estimate.

[6] For a detailed side-by-side comparison of the title I of S. 1 and H.R. 1, please see CRS Report RL31992, *Medicare Prescription Drug Provisions of S. 1, as Passed by the Senate, and H.R. 1, as Passed by the House*, by Jennifer O'Sullivan.

creditable drug coverage, they could elect to continue to receive such coverage, not enroll in Part D, and subsequently enroll in Part D without penalty if they involuntarily lost their other coverage. The Administrator would make direct payments to sponsors of qualified retiree prescription drug plans for each beneficiary enrolled in the plan who was not enrolled in Part D. The amount of the payment would equal a portion of the monthly national average premium for the year, as adjusted by risk adjusters. Additional payments would be made in behalf of persons with drug costs over the catastrophic limit.

Plans would be required to offer "qualified coverage." "Qualified coverage" would be either "standard coverage" or "actuarially equivalent coverage." Both would require access to negotiated prices for all drug costs. In 2006, "standard coverage" would be defined as having a $275 deductible, 50% cost-sharing for drug costs between $276 and the initial coverage limit of $4,500, then no coverage until the beneficiary had out-of-pocket costs of $3,700 ($5,813 in total spending); and 10% cost-sharing thereafter. Out-of-pocket costs counting toward the limit would include costs paid by the individual (or by another individual such as a family member), paid on behalf of a low-income individual under the low-income provisions, paid under Medicaid, or paid under a state pharmaceutical assistance program. Any costs for which the individual was reimbursed by insurance or otherwise could not be counted. Entities could offer more generous drug coverage, if approved by the Administrator, but only if they also offered a plan providing qualified coverage.

Entities would be required to meet a number of beneficiary protection requirements, including those designed to assure beneficiary access to drugs. Eligible entities would be required to have in place procedures to ensure that beneficiaries were not charged more than the negotiated price of a covered drug. Entities would be required to secure the participation in the network of a sufficient number of pharmacies that dispensed drugs directly to patients (other than by mail order) to ensure convenient access for beneficiaries. They would also be required to establish a point-of-service method of operation under which the plan would provide access to any or all pharmacies not participating in the network and could charge beneficiaries, through adjustments in cost sharing, the additional costs associated with this option.

Entities would be required to have in place a cost-effective drug utilization management program and quality assurance measures including a medication therapy management program. Entities could use a variety of cost control mechanisms including formularies, tiered copayments, selective contracting with drug providers, and mail order pharmacies. A formulary would be required to include drugs within all therapeutic categories and classes of covered drugs (although not necessarily for all drugs within such categories and classes). An enrollee would have the right to appeal to obtain coverage for a drug not on the formulary if the prescribing physician determined that the formulary drug was not as effective for treatment of the same condition for the individual or had adverse effects for the individual.

The Administrator would be required to establish service areas in which plans could offer benefits. The Administrator would establish at least 10 service areas which would have to include at least one state. States could not be divided so that portions of a state were in different service areas. To the extent possible, the

Administrator would include multi-state metropolitan statistical areas (MSAs) in a single service area. The Administrator could divide MSAs where necessary to establish service areas of such size and geography as to maximize plan participation. The Administrator could conform service areas to those established for preferred provider organizations under MedicareAdvantage.

Entities would submit bids to the Administrator; the bid would contain information on proposed plans including benefits, actuarial value of the qualified prescription drug coverage, the service area for the plan, and the monthly premium. The Administrator could not approve a plan unless the premium, for both standard coverage and for any additional benefits, accurately reflected the actuarial value of the benefits less the actuarial value of reinsurance payments (paid to plans to cover 80% of costs associated with an individual's spending above the catastrophic level). The Administrator would have the authority to negotiate the terms and conditions of the proposed monthly premiums and other terms and conditions of proposed plans. The Administrator could approve a plan only if it provided the required benefits and was not designed to result in a favorable selection of beneficiaries. The Administrator would approve at least two contracts to offer a Medicare Prescription Drug plan in an area. Contracts would be awarded for 2 years. If the Administrator determined that at least two plans were not going to be available in the subsequent year, the Administrator could reduce the amount of risk required by plans in a region.

Not later than September 1 of each year, beginning in 2005, the Administrator would make a determination as to whether there were two approved bids in an area. If not, the fallback mechanism would apply. Under this mechanism, the Administrator would enter into an annual contract with an entity to provide Part D enrollees in the area with standard coverage (including access to negotiated prices) for the following year. The Administrator could enter into only one contract for each such area. A single entity could be awarded contracts for more than one such area. The Administrator could not enter into such a contract if the Administrator received two or more qualified bids after exercising the authority to reduce risk for entities when fewer than two plans submit a bid. Beneficiary premiums for a fallback plan would be set at the premium amount that would apply if the plan premium equaled the national weighted average premium, as adjusted for geographic differences in drug prices.

Entities would be required to assume financial risk on a prospective basis for costs of benefits in excess of amounts received from premium payments and reinsurance payments. The Administrator would pay each entity offering a Medicare Prescription Drug Plan an amount equal to the full monthly approved premium, subject to adjustments to take into account the differences in risk of different enrollees being served. Payments to plans would be geographically adjusted in a budget neutral manner to account for differences across service areas. The bill would also establish risk corridors, defined as specified percentages above and below a spending target (total premiums less administrative costs). No payment adjustment would be made if allowable costs were within the first risk corridor. A portion of any plan spending above or below these levels would be subject to adjustments. If allowable costs exceeded the level, federal payments would be increased to account for a portion of the excess costs. If they were below the level, a portion of the payments would be reduced.

Beneficiaries would pay their portion of the premiums through a withholding from their social security checks. If the plan's monthly approved premium for standard coverage was greater than the national monthly weighted average premium for such coverage, the beneficiary would pay an additional amount.

Medicaid beneficiaries eligible for medical and drug benefits under their state Medicaid program (including the medically needy) would continue to receive drug benefits through Medicaid. Persons meeting the definition of qualified Medicare beneficiary (QMB, income below 100% of poverty and assets generally below $4,000), specified low-income beneficiary (SLIMB, income below 120% of poverty and assets generally below $4,000) or qualified individual (QI-1, income below 135% of poverty and assets generally below $4,000) and not eligible for Medicaid drug benefits, as well as other persons below 160% of the federal poverty level, would receive their drug benefits through Part D. They would receive assistance for premium and cost-sharing charges.

QMBs, SLMBs and QI-1s would have a 100% premium subsidy for premiums provided the plan premium was at or below the national weighted average premium (or the lowest premium in the area if none was below the national weighted average). The benefit package for the QMB population would be defined as having a zero deductible, cost-sharing of 2.5% for costs below the initial coverage limit; 5.0% cost-sharing for costs above the initial coverage limit and below the annual catastrophic limit, and 2.5% cost-sharing for costs above the catastrophic limit. The benefit package for the SLMB and QI-1 population would be defined as having a zero deductible, 5.0% cost-sharing for costs below the initial coverage limit; 10.0% cost-sharing for costs above the initial coverage limit and below the annual catastrophic limit, and 2.5% cost-sharing for costs above the catastrophic limit.

Persons with incomes below 160% of poverty, not otherwise eligible for low-income benefits or Medicaid drug benefits would have a sliding scale premium subsidy ranging from 100% of the premium at 135% of poverty to 0% at 160% of poverty with no additional premium costs provided the plan premium was at or below the national weighted average premium (or the lowest premium in the area if none was below the national weighted average). The benefit package for this population would be defined as having a $50 deductible, 10.0% cost-sharing for costs below the initial coverage limit; 20.0% cost-sharing for costs above the initial coverage limit and below the annual catastrophic limit, and 10.0% cost-sharing for costs above the catastrophic limit.

States would make low-income eligibility determinations; the federal government would pay an enhanced matching rate for administrative costs associated with making eligibility determinations. Social Security offices would serve as information and enrollment sites.

Medicaid beneficiaries who were eligible for drug benefits under their state Medicaid program would remain in Medicaid. Beginning January 1, 2006, states agreeing to provide a drug benefit to their dual eligible population that was at least equivalent to minimum standards would be relieved of their responsibility to pay Medicare Part B premiums for Medicaid and QMB eligibles between 74% and 100% of the federal poverty level. Further, if on the date of enactment, a state provided

medical assistance to aged and disabled persons up to 100% of poverty, it would be entitled to have the federal government assume the costs for Medicare Part A cost-sharing.

CBO estimates that the new prescription drug benefit (including the temporary drug card program discussed below) would cost an estimated $422 billion over the FY2004 - FY2013 period, without the provision requiring that pharmacy benefit managers disclose certain information. Including that provision, the estimated cost increases to $461 billion. An additional $10 billion in mandatory spending is estimated as the cost of administering the new drug benefit by the new agency. Of the 10-year total for S.1 of $432 billion, CBO estimates that $430 billion represents payments to plans offering qualified prescription drug coverage, $96 billion for low-income subsidies and transitional drug assistance, $45 billion for certain additional Medicare and Medicaid costs, and $10 billion for the government's additional administrative costs. CBO also estimates that some of the costs would be offset by savings to federal drug programs ($17 billion) and by premiums ($132 billion).

House

Title I of the House bill would establish a new Voluntary Prescription Drug Benefit Program under a new Medicare Part D, effective January 1, 2006. The program would rely on private plans to provide coverage and to bear some of the financial risk for drug costs; federal subsidies would be provided to encourage participation. Medicare Advantage (MA) organizations and enhanced fee-for-service (EFFS) plans (see below) would be required to offer plans that included qualified prescription drug coverage. An individual enrolled in a Medicare Advantage Rx plan or EFFS Rx plan would obtain their drug coverage through the plan. An individual not enrolled in either a MedicareAdvantage or EFFS plan could enroll in a new prescription drug plan (PDP). Plans would determine payments and would be expected to negotiate prices. Low-income subsidies would be provided for persons below 150% of poverty. The new Medicare Benefits Administration (MBA), within the Department of Health and Human Services (HHS) would administer the benefit.

Beneficiaries eligible on October 1, 2005, would have a 6-month open enrollment period. Persons becoming eligible after that date would have a 7-month initial enrollment period. Persons enrolling in Part D after their initial enrollment period would be subject to delayed enrollment penalties. However, if they had creditable drug coverage, they could elect to continue to receive such coverage, not enroll in Part D, and subsequently enroll in Part D without penalty if they involuntarily lost their other coverage. The Administrator would make direct payments to sponsors of qualified retiree prescription drug plans for each beneficiary enrolled in the plan who was not enrolled in Part D. The amount of the payment would equal 28% of allowable costs over the $250 deductible but not over $5,000.

Plans would be required to offer "qualified coverage." "Qualified coverage" would be defined as either "standard coverage" or actuarially equivalent coverage. In both cases, access would have to be provided to negotiated prices. For 2006, "standard coverage" would be defined as having a $250 deductible; 20% cost-sharing up to the initial coverage limit ($2,000, accounting for $600 in total out-of-pocket costs and $2,000 in total spending); then no coverage until the beneficiary had out-of-

pocket costs of $3,500 ($4,900 total spending). Once the beneficiary reached the catastrophic ("stop loss") limit, full coverage would be provided. Out-of-pocket costs counting toward the limit would include costs paid by the individual (or by another family member on behalf of the individual), paid on behalf of a low-income individual under the subsidy provisions, under the Medicaid program, or under state pharmaceutical assistance programs. Any costs for which the individual was reimbursed by insurance or otherwise would not count toward incurred costs.

The bill would increase the annual out-of-pocket threshold for each enrollee whose adjusted gross income exceeded a specified income threshold. (Individuals filing joint returns would each be treated separately with each person considered to have an adjusted gross income equal to one-half of the total.) The portion of income exceeding this income threshold ($60,000 in 2006), but below an income threshold limit ($200,000 in 2006), would be considered in making this calculation. The increase would be calculated as follows. First, the ratio of the annual out-of-pocket limit to the income limit would be calculated and expressed as a percent. For 2006, this would be $3,500 divided by $60,000 equaling 5.8%. This percentage would be multiplied by any excess income over $60,000, but not over $200,000. Thus, the catastrophic out-of-pocket limit would be $5,820 for an enrollee with an income of $100,000 and $11,620 for persons with incomes at $200,000 or above.

PDP sponsors and entities offering MA Rx or EFFS Rx plans would be required to meet a number of beneficiary protection requirements, including those designed to assure beneficiary access to drugs. They would be required to permit the participation of any pharmacy that met the plan's terms and conditions. They could reduce copayments below the otherwise applicable level for drugs dispensed through in-network pharmacies; in no case could the reduction result in an increase in subsidy payments made by the Administrator to the plan. They would be required to secure participation in the network of a sufficient number of pharmacies that dispense drugs directly to patients (other than by mail order) to assure convenient access. Sponsors would permit enrollees to receive benefits through a community pharmacy, rather than through mail-order, with any differential in cost paid by enrollees.

The PDP sponsor would be required to have an effective cost and drug utilization management program; quality assurance measures including a medication therapy management program and, for years beginning with 2007, an electronic prescription drug program. Plans could use formularies. The formulary would have to include drugs within each therapeutic category and class of covered outpatient drugs, although not necessarily all drugs within such categories or classes. An individual could appeal to obtain coverage for a drug not on the formulary if the prescribing physician determined that the formulary drug for treatment of the same condition was not as effective for the individual or had adverse effects for the individual.

PDP plan sponsors would be required to enter into a contract with the Administrator. The contract could cover more than one plan. The Administrator would have the same authority to negotiate the terms and conditions of the plans as the Director of the Office of Personnel Management has with respect to Federal Employee Health Benefits (FEHB) plans. The Administrator would be required to take into account subsidy payments for covered benefits in negotiating the terms and

conditions regarding premiums. The Administrator would designate at least 10 service areas, consistent with EFFS regions. Each PDP sponsor would submit information to the Administrator on the qualified drug coverage to be provided, the actuarial value of the coverage, and information on the bid and premium for the coverage The Administrator would review the submitted information for purposes of conducting negotiations with the plan. The Administrator would approve the premium only if it accurately reflected the actuarial value of the benefits and the 73% average subsidy provided for under the bill.

The Administrator would assure that all eligible individuals would have a choice of enrollment in at least two qualifying plan options, at least one of which was a PDP, in their area of residence. The requirement would not be satisfied if only one PDP sponsor or one MA or EFFS organization offered all the qualifying plans in the area. If necessary to ensure such access, the Administrator would be authorized to provide partial underwriting of risk for a PDP sponsor to expand its service area under an existing prescription drug plan to adjoining or additional areas, or to establish such a plan, including offering such plan on a regional or nationwide basis. The assistance would be available only so long as, and to the extent, necessary to assure the guaranteed access. However, the Administrator could never provide for the full underwriting of financial risk for any PDP sponsor.

A PDP sponsor would permit each enrollee to have their premiums withheld from their social security checks in the same manner as is currently done for Part B premiums. Beneficiaries could also make payment of the premium through an electronic funds transfer mechanism.

The bill would provide for subsidy payments to qualifying entities, consistent with an overall subsidy level of 73%. Direct subsidies would be made for individuals enrolled in a PDP, MA Rx or EFFS Rx plan, equal to 43% of the national weighted average monthly bid amount. Reinsurance payments would be provided for 30% of an individual's allowable drug costs within a specified range ($1,001-$2,000 in 2006). Reinsurance, not to exceed 80%, would also be provided for costs over the out-of-pocket threshold ($3,500 in 2006). In the aggregate, reinsurance payments would equal 30% of total payments made by qualifying entities for standard coverage.

The bill would provide income-related subsidies for low-income individuals. Low-income persons would receive a premium subsidy (based on the value of standard coverage). Individuals with incomes below 135% of poverty (as defined under the QMB, SLIMB, and QI-1 programs) would have a subsidy equal to 100% of the value of standard drug coverage provided under the plan. For individuals between 135% and 150% of poverty, there would be a sliding scale premium subsidy ranging from 100% of such value at 135% of poverty to 0% of such value at 150% of poverty. For both groups, beneficiary cost-sharing for spending up to the initial coverage limit would be reduced to an amount not to exceed $2 for a multiple source or generic drug and $5 for a non-preferred drug. Sponsors and entities could not charge individuals receiving cost-sharing subsidies more than $5 per prescription. Sponsors and entities could reduce to zero the cost-sharing otherwise applicable for generic drugs. The determination of whether an individual was a subsidy eligible

individual, and the amount of the subsidy, would be made by the state Medicaid program or the Social Security Administration.

The bill would provide for the phased-in federal assumption of associated administrative costs. The bill would also provide for the federal phase-in of the costs of premiums and cost-sharing subsidies for dual eligibles (i.e., persons eligible for Medicare and full Medicaid benefits, including drugs).

CBO estimates that the new prescription drug benefit (including the temporary drug card program discussed below) would cost an estimated $415 billion over the FY2004 - FY2013 period. Of the 10-year total for H.R.1, CBO estimates that $579 billion represents payments to plans offering qualified prescription drug coverage, $69 billion for low-income subsidies and transitional drug assistance, $5 billion for certain additional Medicare and Medicaid costs. CBO also estimates that some of the costs would be offset by premium income ($139 billion) and by savings to federal drug programs ($99 billion) due to the fact that Part D would replace some Medicaid coverage for certain individuals. Although H.R. 1 does not include direct (not-appropriated) spending for administrative costs of the prescription drug benefit, CBO estimates that the costs to the government would remain the same at $10 billion over the 10-year period, although the actual amount would be subject to the appropriations process.

Temporary Drug Card Program

Both the Senate and House bills would establish a transitional drug card program prior to implementation of the new Part D. Under S.1, the Secretary would establish a temporary program under which the Secretary would endorse programs offered by prescription drug card sponsors meeting certain requirements (including access to negotiated rates) and would make available information on such programs to beneficiaries. A beneficiary could only be enrolled in one endorsed program at a time. Card sponsors could charge annual enrollment fees, not to exceed $25. Beginning no later than January 1, 2004, all individuals meeting the definition of QMB, SLMB, or QI-1, who were not eligible to receive drug benefits under Medicaid, could receive assistance with their prescription drug costs. These persons would have access, through a drug discount card, to up to $600 per year. The entire $600 benefit would be available for the entire year; any balance left on the card in 1 year could be carried forward. Beneficiaries would be subject to cost-sharing requirements which could not be less than 10% of the negotiated price for a drug.

Under H.R.1, the Secretary would be required to establish a temporary program to endorse prescription drug discount card programs meeting certain requirements and to make available information on such programs to beneficiaries. The Secretary would begin operation of the program within 90 days of enactment. The Secretary would provide for an appropriate transition and discontinuation at the time the drug benefits first become available under Part D. The Secretary could not endorse a program unless it met certain requirements. The program would have to pass on to enrollees discounts on drugs, including discounts negotiated with manufacturers. The annual enrollment fee could not exceed $30. The Secretary would establish a prescription drug account for each enrollee and deposit into the account $100; low-income persons would receive a higher federal contribution amount.

On August 5, 2003, Congressman Thomas announced a tentative agreement on the drug card. The press release noted that while the conferees, working through their staffs, worked through scores of issues, some technical drafting needed to be completed. In addition one issue (not specified) needed to be resolved. Under the agreement, nearly $600 would be provided to low-income enrollees.[7]

Medicare Advantage, Preferred Provider Organizations, and Enhanced Fee-for-Service Plans

Senate

S.1 would establish the MedicareAdvantage (MA) program, which would replace the Medicare+Choice (M+C) program. An MA plan could be a coordinated care plan such as a Health Management Organization (HMO), a Provider Sponsored Organization (PSO), a Medical Savings Account (MSA), a Private Fee-for-Service Plan (PFFS), or a regional Preferred Provider Organization (PPO). In general, Medicare beneficiaries entitled to Part A of Medicare and enrolled in both Parts B and D could receive Medicare benefits through the fee-for-service (FFS) program or they could enroll in an MA plan. In addition to current law requirements, each MA plan would be required to offer qualified prescription drug coverage (except for PFFS plans), a maximum limitation on out-of-pocket expenses, and a unified deductible. Beneficiaries enrolling in a PFFS plan without drug coverage could choose to enroll in an eligible entity under Part D.

For payments before 2006, the payment would be calculated in the same manner as under current law; the highest of the blend, the minimum amount (floor) or the minimum percentage increase over the previous year's rate. However, the calculation of the minimum percentage increase would change for 2005. The minimum percentage increase for 2005 would be a 3% increase over the rate for the area in 2003.

Beginning in 2006, MA plans would be paid based on the following new methodology. Plans would submit a bid for their estimate of the cost of providing the required services under the MA program. The Administrator would calculate a weighted service area benchmark. The benchmark amount would be the greater of the minimum amount or the local fee-for-service rate (the amount of payment for a month in an MA payment area for benefits, as well as associated claims processing costs, for an individual who elects to receive benefits under the Medicare FFS program and is not enrolled in an MA plan). The Administrator would pay plans as follows: (1) for plan bids below the weighted service area benchmark, the plan would receive the weighted service area benchmark reduced by the amount of any Medicare Part B premium reduction[8] elected by the plan, and (2) for plan bids that equaled or

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[7] [http://waysandmeans.house.gov/news.asp?FormMode=print&ID=109]

[8] Under current law, beneficiaries share in any projected cost savings between Medicare's payment to a plan and the estimated cost to the plan for offering the Medicare benefits to (continued...)

exceeded the weighted service area benchmark, the MA organization would receive the weighted service area benchmark amount. If the bid was below the weighted service area benchmark (and the amount of any premium reduction elected by the plan plus the plan bid was still below the benchmark), the Secretary would require the plan to provide additional benefits; if the plan bid exceeded the weighted service area benchmark, the plan could charge an MA monthly basic beneficiary premium equal to the full amount the bid exceeded the benchmark.

Beginning January 1, 2006, preferred provider organization (PPO) plans would be offered to MA eligible individuals in preferred provider regions. There would be at least 10 regions established and each region would have to include at least one state (a region could be the entire United States). If there were bids for more than 3 plans in a preferred provider region, the Administrator would limit the number of plans to the 3 lowest-cost credible plans that met or exceeded the quality or minimum standards. The Administrator would calculate a benchmark amount for required services for each region equal to the average of each benchmark amount for each MA payment area within the region, weighted by the number of MA eligible individuals residing in the payment area for the year. Each plan would submit a bid for coverage of required benefits. The Administrator would pay plans as follows: (1) for bids below the regional benchmark, the plan would receive the regional benchmark less the amount of any Medicare Part B premium reduction elected by the plan, and (2) for bids that equaled or exceeded the regional benchmark, the MA organization would receive the regional benchmark amount. If the bid was below the regional benchmark (and the amount of any premium reduction elected by the plan plus the plan bid was still below the benchmark), the Secretary would require the plan to provide additional benefits beyond any premium reduction. If the plan bid exceeded the regional benchmark, the plan could charge an MA monthly basic beneficiary premium equal to the full amount by which the bid exceeded the benchmark. Additionally, risk corridors would be established so that PPOs would not initially be responsible for the risk of paying for all the medical benefits, in 2006 and 2007.

Beginning in 2008, the Administrator would establish a limited program in highly competitive areas, for which payments to plans would be based on bids in place of the regional benchmarks. The Administrator would be required to designate a limited number, but not less than 1, preferred provider region as "highly competitive." For each subsequent year, the Administrator could designate a limited number of additional regions as highly competitive. If an area was designated as highly competitive, the regional benchmark would not apply. Instead, a plan would submit a bid for the total amount it was willing to accept for providing required Parts A and B benefits to plan enrollees, and the Administrator would substitute the second lowest bid for the benchmark. If there were fewer than 3 bids, the Administrator would be required to substitute the lowest bid for the benchmark. Funding for this

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[8] (...continued)
its commercial enrollees. To accomplish this, plans must provide either reduced cost-sharing or additional benefits to their Medicare enrollees that are valued at 100% of the difference between the projected cost of providing Medicare-covered services and the expected revenue for Medicare enrollees. Additionally, beginning in 2003, plans may also reduce the Medicare Part B premium.

program would be limited to $6 billion in addition to what would have been expended if this program was not in effect. The funding would be available for 2009 through 2013.

CBO estimates that direct spending for Title II (over the 10-year period of FY2004-FY2013) would increase by an estimated $18.3 billion. Of that total, $6 billion would be for the MA program, $6 billion for the PPOs, $6 billion for the fee-for-service modernization provision and $0.1 for other provisions.

House

H.R. 1 would establish the Medicare Advantage (MA) program to replace the M+C program, which would continue to offer coordinated care and other plans on a county-wide basis as under current law. In 2006, the bill would also establish the Medicare Enhanced Fee-for-Service (EFFS) program under which Medicare beneficiaries would be provided access to a range of regional EFFS plans that could include preferred provider networks. Beginning in 2010, EFFS and MA plans in specially designated competitive areas would begin to phase-in competitive bidding in the same style as the Federal Employees Health Benefits program (FEHBP). Beneficiaries in MA or EFFS plans would not be required to enroll in Part D. However, at least one plan offered by an MA organization in an area and at least one plan offered by an EFFS organization in a region would be required to offer Part D prescription drug coverage. Therefore, if the beneficiary only had one available MA plan and/or one available EFFS plan from which to chose, then in effect, the beneficiary would have to enroll in Part D in order to enroll in a plan.

Under the new MA program, payments to MA plans would be modified. For 2004, a 4th payment mechanism would be added so that plans would be paid the highest of the floor, minimum percent increase, the blend, or the new amount. The new payment amount would be 100% of FFS. The FFS payment would be based on the adjusted average per capita cost for the year for an MA payment area, for services covered under Parts A and B of Medicare for beneficiaries entitled to benefits under Part A, enrolled in Part B and not enrolled in an MA plan. Changes would be made to the blend payment in 2004, so that there would be no adjustment for budget neutrality in that year. The calculation of the minimum percentage increase would also be revised. For 2004 and beyond the minimum percentage increase would be the greater of a 2% increase over the previous year's payment rate (as under current law), or the previous year's payment increased by the national per capita MA growth percentage.

Beginning in 2006, the Administrator would determine MA payment rates by comparing plan bids to the benchmark. Plans would submit bids for providing required Parts A and B benefits. The benchmark would be calculated by updating the previous year's capitation rate by the annual increase the minimum percentage increase. For plans with bids below the benchmark, the payment would equal the unadjusted MA statutory non-drug monthly bid amount, as adjusted, and the rebate. The rebate would equal 75% of any average per capita savings (the amount by which the risk-adjusted benchmark exceeded the risk adjusted bid). The remaining 25% of the average per capita savings would be retained by the federal government. For plans with bids at or above the benchmark (for which there were no average per

capita monthly savings), the payment amount would equal the FFS area-specific non-drug monthly benchmark amount, as adjusted. For the plans with bids above the benchmark, the enrollee's premium would be equal to the full amount by which the bid exceeded the benchmark.

Beginning in 2006, the Administrator would also establish the EFFS program. EFFS plans would be required to provide either FFS or preferred provider coverage, on a regional basis. There would be at least 10 regions established and the Administrator could enter into contracts with up to 3 EFFS organizations in any region. Each year an EFFS organization would submit a monthly bid amount for each plan in each region (the EFFS monthly bid amount). The Administrator would calculate a benchmark amount equal to one-twelfth of the average (weighted by the number of EFFS eligible individuals in each payment area) of the annual MA capitation rate calculated for that area. For plans with bids below the benchmark (for which there were average per capita monthly savings), the payment would equal the unadjusted EFFS statutory non-drug monthly bid amount, as adjusted, and the rebate. The EFFS plan would provide the enrollee a monthly rebate equal to 75% of the average per capita savings. For plans with bids at or above the benchmark (for which there were no average per capita monthly savings), the payment amount would equal the EFFS region-specific non-drug monthly benchmark amount, as adjusted. For the plans with bids above the benchmark, the enrollee's premium would be equal to the full amount by which the bid exceeded the benchmark.

Beginning in 2010, this bill would provide for the phase in of a new payment system for "competitive EFFS regions" and "competitive MA areas" (CMAs) defined as a region (or in the case of a CMA, an area) that during open season offered at least two EFFS plans (or in the case of a CMA, at least two MA plans) by different organizations, each of which met minimum enrollment requirements. Additionally, in order to be designated as a competitive EFFS region or CMA, the region/area would have to have a minimum percentage of eligible beneficiaries who were enrolled in either an EFFS or MA plan. Payments would be based on a competitive bidding system, so that the benchmark for these competitive regions/areas would be calculated using a statutory formula that included a weighted average of plan bids for the region/area. Similar to the rebates under the EFFS and MA programs for non-competitive regions/areas, beneficiaries in competitive regions/ areas would receive a rebate equal to 75% of the average per capita monthly savings, for plans with bids below the competitive benchmark. For plans with bids above the benchmark, the enrollee's premium would be equal to the full amount by which the bid exceeded the benchmark. Payments in competitive regions/ areas would be phased in over 5 years, so that the first year the payment would be based on 1/5 of the competitively determined payment rate and 4/5 of the non-competitively determined payment rate.

A beneficiary residing in a competitive region/area who was covered under FFS Medicare and not enrolled in either an MA or EFFS plan, could have an adjustment to their Part B premium, either as an increase or a decrease. For competitive regions/areas, if the FFS region/area-specific non-drug amount for the month did not exceed benchmark for the competitive region/area, the beneficiary's Part B premium would be reduced by 75% of the difference. If the FFS region/area specific non-drug amount for the month equaled or exceeded the benchmark for the competitive

region/area, the beneficiary's Part B premium would increase by the full amount of the difference.

CBO estimates that over the 10-year period FY2004 - FY2013, direct spending would be increased by $7.5 billion for the provisions of Title II. Of that total, $1.6 billion would be for payments to MA plans, $6.4 billion for payments to EFFS plans, $0.4 billion for premium rebates for beneficiaries who switch from Medicare FFS to plans under the competitive program that begins in 2010, and $0.2 for other provisions. Offsetting those costs, CBO estimates savings from the competitive program's payments to plans and providers ($0.6 billion) and premium rebates for beneficiaries who remain in plans under the competitive program ($0.5 billion).

New Agency to Administer Medicare Part C and Part D

Both bills would establish a new agency within the Department of Health and Human Services (HHS) to administer MedicareAdvantage, and Part D, prescription drugs. H.R. 1 would also have the new agency administer EFFS. In general, the provisions found in the Senate and House bills are very similar. Both would establish a presidentially-appointed administrator who would report directly to the Secretary and exercise all powers and duties of the agency. The Administrator would negotiate, enter into, and enforce contracts with MedicareAdvantage plans (and EFFS plans in the House bill) and with the prescription drug plan offerors. The Administrator would hire staff for the new agency. The S.1 would leave current executive branch civil service laws in place, while H.R. 1 would waive Chapter 31 of Title 5 of the U.S. Code (which addresses authority for employment), except for 12 sections that would be retained: Sections 3102 - 2108, 3110-3113, 3136m, and 3151.[9] H.R. 1 would also waive Chapter 51 (regarding job classification), except Section 5101 requiring classification of positions according to certain principles, and

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[9] The 12 sections of chapter 31 that would be retained are: **3102**, permitting agencies to hire personal assistants for handicapped employees; **3103**, requiring employees to render services in connection with and for the purposes of the appropriation from which the individual is paid; **3104**, permitting the Director of the Office of Personnel Management (OPM) to establish, and revise, the maximum number of scientific or professional positions outside of the General Schedule for carrying out research and development functions; **3105**, requiring agencies to appoint as many administrative law judges (ALJs) as are necessary for hearings and other such proceedings; **3106**, prohibiting agency heads from employing private attorneys in litigation that is against the agency and requires the matter be referred to the Department of Justice; **3107**, prohibiting the employment of publicity experts unless specifically appropriated for that purpose; **3108**, prohibiting the employment of Pinkerton Detective Agency employees or employees from similar organizations; **3110**, prohibiting the employment of relatives; **3111**, permitting agencies to accept volunteer services of students; **3112**, giving hiring preferences to veterans; **3113**, barring federal re-employment if the employee is convicted of certain specified crimes relating to bribery of a public official and drug related crimes; **3136m**, no such provision; and **3151**, permitting the Attorney General to establish a personnel system for senior executives in the FBI and DEA. Among the 8 sections that would be waived are those establishing the Senior Executive Service.

Chapter 53 (regarding pay rates and systems), except Section 5301 establishing principles of pay systems.

Both bills would create an Office of Beneficiary Assistance within the new agency to coordinate Medicare beneficiary outreach and education efforts and to provide Medicare benefit and appeals information to beneficiaries. Both bills would create an advisory board within the new agency to advise, consult with, and make recommendations to the Administrator. The board recommendations would be submitted directly to Congress without any review within the federal government.

The Senate bill would name the new agency the Center for Medicare Choices. The provision creating the agency is found in Title III. The House bill would name the new agency the Medicare Benefits Administration. The provision creating the new agency is found in Title VIII.

S. 1 would fund the administrative expenses for implementing Part D through mandatory appropriations, with the remainder of the new agency's responsibilities funded by the annual appropriations process. H.R. 1 would make the new agency's entire administrative funding subject to the annual appropriations process. CBO estimates that the new administrative costs to the government for the administrative tasks implementing Parts C, and D (and E in H.R. 1) would be $10 billion from FY2004 - FY2013. However, because, depending upon the bill, most or all of these funds are subject to appropriations, the appropriations committees have discretion to determine the actual level at which these new requirements would be funded.

Appeals, Regulatory, and Contracting Provisions[10]

Both the Senate bill in title V and the House bill in title IX contain numerous provisions addressing Medicare appeals, regulatory relief and contracting reform. Both titles were drawn from previously introduced legislation – S. 3018 that was introduced in the 107th Congress, and H.R. 810 that was introduced in the 108th Congress and reported out of both the Ways and Means and Energy and Commerce Committees. These titles were the first that the Conferees addressed and, on July 24, 2003, an agreement was announced on these provisions.[11]

These provisions would modify how Medicare regulations and guidance are communicated; would modify the procedures used to resolve payment disputes; and would establish various provider appeal processes, particularly for those who face termination of Medicare participation or denial of their application to participate in the program. As well as attempting to minimize Medicare's administrative burden, the bills would give the Secretary the authority to competitively contract for claims processing services with any qualified entities; establish that these contracts be

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[10] For a detailed side-by-side comparison of the regulatory reform titles of S. 1 and H.R. 1, please see CRS Report RL31901, *Regulatory Reform Provisions of S. 1, as Passed by the Senate, and H.R. 1, as Passed by the House,* by Jennifer Boulanger and Sibyl Tilson.

[11] The text of the agreement is on the House Committee on Ways and Means website http://waysandmeans.house.gov/media/pdf/healthdocs/regreformagreement.pdf .

competitively bid at least every 5 years; and place new requirements on the Medicare claims processing contractors, including an increased emphasis on provider education. The bills would refine the information required to be provided in the appeals process and make other modifications. Under the announced agreement, the administrative law judge (ALJ) function for Medicare hearings would be transferred from the Social Security Administration (SSA) to HHS, by October 1, 2005. Other program changes, demonstration projects, and mandated studies are also included in the bills.

Many of the provisions codify initiatives underway within the Centers for Medicare and Medicaid Services (CMS), the agency that administers Medicare, under its current authority. The proposed legislation authorizes increased funding but action by the appropriations committees would be required for CMS to receive additional money.

CBO has estimated that implementing S. 1 and H.R. 1 would cost $4 billion over the FY2004 through FY2013 period. However, this is an estimate of the increase in discretionary costs and thus, is subject to action by the appropriations committees.

Provisions Affecting Medicare's Fee-for-Service Program Payments, Beneficiary Cost-sharing Amounts and Covered Benefits[12]

Both bills contain significant payment increases, certain payment reductions, expansion of covered benefits, establishment of demonstration projects and required studies as well as new beneficiary cost-sharing provisions in the Medicare fee-for-service (FFS) program. Provisions affecting the Medicaid program are included in both bills as well. The majority of Medicare's FFS payment and benefit changes in S. 1 are in Title IV and Title VI. Medicaid and other health-related provisions are also included in Title VI. Comparable Medicare FFS changes are in Title III through Title VII of H.R. 1; the Medicaid provisions in H.R. 1 are in Title X.

Several general observations regarding the Medicare FFS modifications can be made:

- The actual monetary benefit accruing to the various providers, physicians, or suppliers will vary depending upon the specific structure of the payment adjustment; these payment adjustments are different in S. 1 and H.R. 1. Of course, the actual benefit accruing to any individual provider or physician will depend upon a myriad

[12] For a detailed side-by-side comparison of the fee-for-service provisions of the bills, see CRS Report RL32005, *Medicare Fee-for-Service Modifications and Medicaid Provisions of S. 1, as Passed by the Senate, and H.R. 1, as Passed by the House*, by Sibyl Tilson, Jennifer Boulanger, Jean Hearne, Evelyne Baumrucker, and Julie Stone.

of unique circumstances, such as the characteristics of the provider or physician, including urban or rural location, as well as the amount and types of services provided to the Medicare beneficiaries who are served;

- Both bills have spending reductions for particular providers or suppliers. S. 1 would freeze certain durable medical equipment (DME) fee schedules. H.R. 1 proposes reductions in the updates for hospitals, ambulatory surgery centers, and home health services, and would also freeze per resident payment amounts for direct graduate education reimbursement to high cost hospitals. To some extent, however, reductions in either bill are counterbalanced by other payment changes that increase Medicare payments to particular subsets of the affected providers or suppliers.
- Both bills increase beneficiary cost-sharing amounts in traditional Medicare, but in different fashions and for different services. Both bills schedule annual increases in the Part B deductible amount that must be met before program payments will be made for covered Part B services. S. 1 sets the deductible amount at $125 in 2006 and provides for annual increases based on changes in the consumer price index for urban consumers (CPI-U) each year thereafter. H.R. 1 would increase the Part B deductible annually as well, but would do so beginning in 2004 off the current base of $100 and would use the same percentage amount traditionally used to increase the Part B premium. This update would be the annual percentage increase in the monthly actuarial value of benefits payable from the Federal Supplementary Medical Insurance Trust Fund (rounded to the nearest dollar). S. 1 establishes beneficiary coinsurance and deductible requirements for clinical laboratory services in most settings; H.R. 1 establishes a beneficiary copayment for each 60-day episode of home-health care at 1.5% of the national average payment rate per episode. Absent timely regulatory action, the copayment would be set at $40 in 2004.
- H.R. 1 provides for improved coverage of preventive services, including an initial preventive examination, and waives the deductible for certain cancer screening tests. S. 1 provides for increased Part B coverage of self-injected drugs.

CBO estimates that the net effect of the Medicare fee-for-service provisions of S. 1 would reduce federal spending by $16 billion over the 10-year, FY2004 - FY2013 period. S. 1 would offset additional fee-for-service spending by imposing copayments on certain laboratory services, freeze payments for durable medical equipment, prosthetics, and orthotics, increase the length of time that Medicare is secondary payer for end-stage-renal disease patients, and require the Internal Revenue Service to deposit fees from installment agreements The fee-for-service provisions of H.R. 1 are estimated to reduce federal spending by $21 billion over the 10-year period. H.R. 1 would offset additional fee-for-service spending by establishing copayments for home health services, change hospital inpatient payment rates, and implement competitive bidding for currently covered outpatient drugs and durable medical equipment.

The following general points can be made about the Medicaid provisions:

- Both bills temporarily increase states' disproportionate share hospital (DSH) allotments to erase the decline in these Medicaid amounts that occurred after a special rule for their calculation expired.
- S. 1 includes several other Medicaid provisions, including raising the floor on DSH allotments for "extremely low DSH states", increasing the federal matching share of certain Medicaid payments in the state of Hawaii, and allowing states to cover certain lawfully residing aliens under the Medicaid program.

CBO estimates that the Medicaid and SCHIP provisions of S. 1 would increase direct spending by $2.8 billion and H.R.1 would increase spending by $3.8 billion from FY2004 - FY2013.