Committee on Ways and Means

Summary of Medicare Conference Agreement

Title I – Medicare Prescription Drug Benefit

Prescription Drug Discount Card

- The Medicare-endorsed drug discount cards will be available no later than 6 months after enactment, and would end when the prescription drug benefit becomes available to the beneficiary in 2006.
- Beneficiaries would have a choice of at least two Medicare endorsed cards.
- All Medicare beneficiaries would be eligible for the card, except those enrolled in Medicaid and entitled to Medicaid drug coverage.
- Card sponsors could charge an annual enrollment fee of up to $30, which may be paid by a State.
- Card sponsors would offer beneficiaries access to negotiated prices and discounts.
- Sponsors must provide convenient access to pharmacies

Transitional Low-Income Assistance

- All individuals with income under 135% of the federal poverty level would be eligible for transitional assistance unless they have third party coverage from employers, Department of Defense, Medicaid or the Federal Employees' Health Benefit Program.
- There would be no asset test (unlike Medicaid.)
- Up to $600 per year would be provided in conjunction with the discount card to purchase prescription drugs, but the amount may be prorated for beneficiaries who enroll for part of a year.
- The annual enrollment fee would be paid by the Secretary.
- Eligible beneficiaries below 100% of FPL would pay a 5% coinsurance on each discounted drug; eligible beneficiaries between 101%- 135% of FPL would pay a 10% coinsurance on each discounted drug.

Prescription drug benefit

Standard Benefit in 2006

- $250 deductible
- 75% coverage to $2,250
- $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; 20% above 5%.)
- $35 average premium

Guaranteed Plan

- 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.

Quality Measures Related to Prescription Drugs

Medication Therapy Management

- Plans must have programs to provide medication therapy management by pharmacy providers targeted to beneficiaries who (1) have multiple chronic conditions, (2) use multiple prescriptions and (3) are likely to incur high drug expenses.

- These programs would ensure appropriate use of prescription drugs to improve therapeutic outcomes and reduce adverse drug interactions.
- Plans must take into account medication therapy management services when determining reimbursement for pharmacists.

Electronic Prescribing

- Plans may operate electronic prescription programs that meet federal standards.
- Prescribing health providers would receive relevant information from plans on medical history, lower cost drugs, eligibility and benefits, drugs included on the formulary, and information on potential adverse drug interactions.
- The Secretary, in consultation with appropriate stake holders, would develop and adopt initial standards by September 1, 2005. A pilot program to test the initial standards would begin January 1, 2006. The Secretary would evaluate the pilot program, submit a report to Congress by April 1, 2007 and issue final standards by April 1, 2008.
- Discretionary grants would be available to assist providers in implementing electronic prescription programs.
- Plans, hospitals and group practices would be allowed to purchase hardware and software for doctors in establishing the programs.
- Prescription drug plans may pay an additional fee to doctors who reduce medical errors, improve formulary compliance or reduce adverse drug interactions.

Title II – Medicare Advantage Program

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% of the savings from plans bidding below the benchmark going to beneficiaries and 25% to the government.
- 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), or 25% of qualifying MSAs if lower, 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.
- Cost contracts extended indefinitely unless, beginning in 2008, 2 private local plans or 2 private regional plans serve are available to the cost contract's enrollees.
- Plans which serve beneficiaries with specialized needs could restrict coverage to those beneficiaries through 2009.
- Municipal health service demonstrations would be extended through 2006.
- PACE providers and individuals enrolled in PACE would receive the same balance billing protections as other Medicare+Choice plans.

Title III – Combating Waste, Fraud and Abuse

Recovery Audit

- The Secretary would conduct a demonstration of recovery audit contractors in at least two states for three years to identify under or overpayments and collect overpayments.

Durable Medical Equipment

- Durable medical equipment rates will be frozen for three years from 04-06. The rates for the top 5 codes will be adjusted to reflect prices paid under the FEHBP plans, affecting a small proportion of the items and services. 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.

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 6% 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.
    - Adjust for higher oncology nurse salaries.
    - Add transitional payment increase in 2004 and 2005.
    - 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.

Medicare Secondary Payer

- Clarify Medicare Secondary Payer policies, thereby saving $9 billion...

Title IV – Rural Provisions

Rural Health Care Improvements

- Standardized amount made permanent.
- 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 hospital payment: Number of discharges is 800. Must meet 25 mile limitation.
- Redistribution of unused graduate medical education payments to rural hospitals and small city hospitals.
- Nurse practitioners will be able to continue to treat their patients who enroll in hospice programs.
- Critical Access Hospital (CAH) program would be improved, including:
    - an increase in the payment amounts to 101% of costs;
    - up to 25 beds can be used for acute care;
    - new eligibility rules that allow hospitals with no greater than 10 psychiatric or rehabilitation beds to become CAHs;
    - on-call payments to physician assistants, nurse practitioners, and clinical nurse specialists;
    - reinstate the periodic interim payments and develop alternative timing methods to achieve an appropriate level of cash flow;
    - eliminate the barrier for receiving the physician bonus; and
    - authorize $35 million a year in Rural Flexibility Grants, with 95% of the funds going to the hospitals.
- Consolidated billing is eliminated for the professional services provided by rural health clinic and federally qualified health clinic services.

- The hold harmless for hospital outpatient services performed at small rural hospitals would be extended for two years. During this time period, the Secretary will review the prospective payment system rates.
- A safe harbor is created for donations and other remuneration used to improve services at Federally Qualified Health Centers.
- Hospitals that are missing cost reports will be eligible for sole community status if one base year cost report is available.

Title V – Part A

Provisions Relating To Part A

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 for those hospitals that fail to 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.
- Medicare payments to skilled nursing facilities will be refined to reflect the high cost of treating patients with AIDS.
- An appeals structure for wage index reclassification is created, removing arbitrary distance criteria and focusing on quality and other factors. It results in as much as $900 million in new hospital payments.
- A new process is established, similar to the current wage index reclassification process, based on commuting data, which would enable hospitals to receive a blended wage index amount based on the percent of employees which commute from adjacent MSAs.
- The PPS rate for hospitals in Puerto Rico would be permanently increased to 75% of the national rate over a 2 year transition.

- The Department of the Treasury would be allowed to correct a technical error regarding the HI Trust Fund.
- Hospice physicians will be reimbursed for educating patients about the program.
- The Secretary will update the weights for the hospital market basket more frequently than once every 5 years.

Title VI – Part B

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 5% bonus payments 2005-2007.
- Screening tests would be covered for early detection of cardiovascular disease.
- Individuals at high risk for diabetes would be covered for laboratory screening tests.
- Mammography payments provided in hospital outpatient departments would be paid under the higher rates in the physician fee schedule.
- Certain sole source drugs in the hospital outpatient setting will be paid at least 88% of AWP in 2004 and at least 83% of AWP in 2005, but no more than 95% of AWP. Multiple source drugs would be paid no more than 68% and generic drugs would be paid no more than 46%. The General Accounting Office will collect data on hospital acquisition costs for drugs. The provision recognizes variation in the costs for brachytherapy seeds.
- An advisory board is established to provide advice for the end stage renal disease demonstrations underway by the Centers for Medicare and Medicaid Services.
- The payments for exceptionally costly care are restored for facilities that primarily treat pediatric dialysis patients.
- Podiatrists, dentists and optometrists would be included under private contracting authority.
- A fee schedule amount is established for custom shoes for diabetic patients.
- Two year moratorium on the therapy cap.

Laboratory Payments

- 5 year freeze on laboratory payments.

Ambulatory Surgical Centers

- 1% reduction in payments beginning April 2004.
- 5 year freeze in payment rates, 2005-2009.
- Secretary to develop new payment system after review of GAO study.

Title VII – Parts A and B

Provisions Relating To Parts A and B

- The Secretary shall conduct a demonstration to test a less restrictive home bound definition used for eligibility for home health services.
- A new open process and timelines are established for national coverage decisions. Clinical trials are covered for Category A devices.
- The Secretary shall conduct a demonstration for home health services delivered at medical adult day care centers.
- The Medicare Payment Advisory Commission will be required to examine the budgetary requirements of their recommendations. MedPAC members must fully disclose their finances. The Commission shall include at least one member with pharmaceutical expertise.

Home Health

- No copayment.
- MB –0.8 for 2004-06.
- 5% rural bonus payment for one year.

Other

- 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.

Beneficiary Issues

- Provide initial voluntary physical when becoming eligible for Medicare.
- Cover new preventive benefits: screening for diabetes and cardiovascular disease.
- Part B deductible at $110 in 2005 and indexed to growth in Part B expenditures.
- Provide a disease management program to manage and promote health for those with chronic illnesses.

Title VIII – Cost Containment

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.

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.)

Title IX – Regulatory and Contracting Reform

Regulatory Reform

- Prohibits the introduction of new material in final rules without an opportunity for public comment.
- Prohibits retroactive application of new regulations and policies.
- Prohibits sanctions if a provider follows written, erroneous guidance from the government and its agents.

Contracting Reform

- Creates a competitive process for contracting for Medicare administrative functions such as processing and paying of claims. In addition, expands the potential pool of expertise by allowing companies besides insurance companies to compete for contracts.

Appeals

- Transfers Medicare Administrative Law Judges from the Social Security Administration to the Department of Health and Human Services to ensure their independence.
- Expedites access to judicial review for legal issues that cannot be resolved administratively, and requires expedited review of certain provider agreement determinations.
- Allows providers up to three years to repay overpayments in cases of hardship (five years if extreme hardship).

Title X – Medicaid and Miscellaneous Provisions

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.

Title XI – Access to Affordable Pharmaceuticals

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.

Title XII – Tax Provisions

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 lifetime health care needs
    - Contributions to the account are tax free.
    - Build up in the account is tax free.
    - Distributions from the account are tax free.

        - Contributions can be made by individuals, their employers, and family members – all on a tax-free basis
        - Up to 100% of the health plan deductible may be saved annually, up to a maximum of $2,600 for self-only policies and $5,150 for family policies
        - Individuals age 55-65 (peak savings years) can make additional tax-free "catch-up" contributions of up to $1,000.
        - Distributions used to pay un-reimbursed medical expenses are completely tax free. Distributions can be used to pay for retiree health insurance, Medicare expenses, prescription drugs, and many other expenses.

- The 28 percent employer subsidy for retiree prescription drug coverage is excludable.