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Medicare Prescription Drug and Reform Legislation

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Jennifer O'Sullivan, Hinda Chaikind, Sibyl Tilson, Jennifer Boulanger, and Paulette Morgan
Specialists and Analyst in Social Legislation
Domestic Social Policy Division

Medicare Prescription Drug and Reform Legislation

Summary

The Senate and House are both actively considering major legislation to add a prescription drug benefit to the Medicare program. The bills would also establish a new MedicareAdvantage program (Medicare Advantage program in the House bills) to replace the current Medicare+Choice program. Under the newly established program, plans (largely health maintenance organizations) would be paid based on a system of bids and benchmarks, as opposed to the current law methodology of basing payments on a formula set in law. Both bills would also establish regional plans, referred to as Preferred Provider Organization (PPO) plans under the Senate bill and Enhanced Fee-for-Service (EFFS) plans under the House bill. Drug benefits and the new Advantage program 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.

On June 12, 2003, the Senate Finance Committee ordered reported S. 1, the Prescription Drug and Medicare Improvement Act of 2003. The Senate began floor debate on the measure on June 16, 2003. The House Ways and Means Committee ordered reported H.R. 2473, the Medicare Prescription Drug and Modernization Act of 2003, on June 17, 2003. The House Energy and Commerce Committee (which shares jurisdiction over Medicare) began to mark-up slightly different versions of the bill on June 17, 2003. Any differences in the bills reported by the two committees are to be resolved before the legislation is considered by the full House at the end of the month.

This report describes the major features of S. 1, as ordered reported, and the measure to be considered by the House Ways and Means Committee, H.R. 2473, as ordered reported. It will be updated to reflect legislative activity.

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The Senate and House are beginning consideration of legislation to add a prescription drug benefit to Medicare and reform a number of aspects of the program. On June 12, 2003, the Senate Finance Committee ordered reported S. 1, the Prescription Drug and Medicare Improvement Act of 2003. The Senate began floor debate on the measure on June 16, 2003. The House Ways and Means Committee and the House Energy and Commerce Committee (which share jurisdiction over Medicare) began to mark-up slightly different versions of the Medicare Prescription Drug and Modernization Act of 2003, beginning June 17, 2003. Any differences in measures reported by the two committees are to be resolved before the measure is considered by the full House at the end of the month.

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 that are currently under consideration. This report describes the major features of S. 1, as ordered reported, and the measure to be considered by the House Ways and Means Committee, as displayed on its Web site on June 17, 2003.

Prescription Drugs

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 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.

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.

Prior to implementation of the new Part D, 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.

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. MedicareAdvantage (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 ($1,000-$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).

The bill would require the Secretary 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.

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

Senate

This bill 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 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) and 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.

Each year the Administrator would calculate a benchmark amount for each MA payment area with respect to coverage of benefits available under Medicare FFS. The benchmark would be the greater of one-twelfth of the annual M+C capitation

rate for the payment area for the year 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).

For payments before 2006, the payment would be the same as under current law. 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 one-twelfth of the annual M+C capitation rate for the payment area for the year or the local fee-for-service rate. The Administrator would pay plans as follows: (1) for plan bids that equal or exceed the weighted service area benchmark, the MA organization would receive the weighted service area benchmark amount, and (2) for plan bids below the weighted service area benchmark, the plan would receive the weighted service area benchmark reduced by the amount of any premium reduction elected by the plan.

Beginning January 1, 2006, a preferred provider organization (PPO) plan would be offered to MA eligible individuals in preferred provider regions. There would be at least 10 regions and each region would have to include at least one state. The Administrator would calculate a benchmark amount 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 that equal or exceed the regional benchmark, the MA organization would receive the regional benchmark amount and (2) for bids below the regional benchmark, the plan would receive the regional benchmark reduced by the amount of any premium reduction elected by the plan. Risk corridors would be established so that PPOs would not initially be responsible for all the risk of the medical benefits, in 2006 and 2007.

House

This bill would establish the MedicareAdvantage (MA) program, which would replace the M+C program. In 2006, the bill would also establish the Medicare Enhanced Fee-for-Service (EFFS) program to offer EFFS plans to EFFS eligible individuals in one of 10 regions, under which Medicare beneficiaries would be provided access to a range of 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).

The bill would establish the MA program under Part C of Medicare. For payments before 2006, the payment amount would equal one-twelfth of the annual MA capitation rate, for an individual for that area, reduced by any premium reduction, as adjusted. Beginning in 2006, the administrator would pay plans as follows. For plans below the benchmark (for which there were average per capita monthly savings -the amount by which the risk-adjusted benchmark exceeds the risk-adjusted bid), the payment would equal the unadjusted MA statutory non-drug

monthly bid amount, as adjusted. 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.

Beginning in 2006, EFFS plans would be required to provide either FFS or preferred provider coverage, on a regional basis. Each year, beginning in 2006, 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 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. 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.

Beginning in 2010, this bill would provide for the phase in of a new payment system for "competitive EFFS regions" defined as a region that during open season offered at least two EFFS plans the previous year, each of which met minimum enrollment requirements. Additionally, in order to be designated as a competitive EFFS region, the region would have to have a minimum percentage of eligible beneficiaries enrolled in either an EFFS or MA plan. The bill would also establish "competitive MA areas", with similar requirements. Payments would be based on a competitive bidding system, with plans competing with each other and with the traditional Medicare program. Similar to the rebates under the EFFS and MA programs for non-competitive areas, beneficiaries in competitive regions or areas would receive a rebate equal to 75% of the average per capita monthly savings.

All enrollees in competitive areas, including FFS enrollees, EFFS and MA enrollees, could have an adjustment to their Medicare Part B premium, resulting in either a higher or lower monthly Part B premium.

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. 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 enhanced fee-for-service in the House bill) and with the prescription drug plan offerors. The Administrator would hire staff for the new agency. The Senate bill would leave current executive branch civil service laws in place, the House bill 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.[1] The House bill would also waive Chapter 51 (regarding job classification), except Section 5101 requiring classification of positions according to certain principles, and 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 and the provision creating the agency is found in Title III. The House bill would name the new agency the Medicare Benefits Administration and the provision creating the new agency is found in Title VIII.

Appeals, Regulatory, and Contracting Provisions

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. The Senate provisions were drawn from S. 3018[2] that was introduced in the 107th Congress and the House provisions were drawn from H.R. 810 of the 108th Congress.[3] These two titles are substantially similar.

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[1] 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.

[2] A summary of the major provisions of S. 3018 can be found in the CRS Report RL31610, *Major Medicare Provisions of H.R. 4954, As Passed by the House, and S. 3018*, by Jennifer O'Sullivan, Hinda Chaikind, and Sibyl Tilson.

[3] A complete summary of the provisions of H.R. 810 can be found in the CRS Report (continued...)

These titles 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 competitively bid (at least every 6 years in the Senate bill and every 5 years in the House bill); 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. The Senate bill would require a report on transferring the administrative law judge (ALJ) function for Medicare hearings from the Social Security Administration (SSA) to HHS. The House bill, in addition to the report, would require transferring the ALJ function 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.

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

The proposed Medicare reform legislation under consideration in both the House and the Senate contain various provisions that adjust program and beneficiary payments for different covered services provided in traditional (or fee-for-service, FFS) Medicare. Certain provisions modify the covered benefits as well. A comparison of the majority of significant provisions affecting FFS provider payments, beneficiary cost-sharing amounts and covered FFS benefits can be found in the table below. By necessity, the provision descriptions are brief; however a section reference has been included for the provisions in both S. 1 and the House bill to assist readers in finding the specific legislative language.

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[3] (...continued)
RL31901, *Major Provisions of H.R. 810, As Reported by the House Ways and Means Committee and the Energy and Commerce Committee*, by Jennifer Boulanger and Sibyl Tilson.

Several general points can be made:

- the actual monetary benefit accruing to specific kinds of providers, physicians or suppliers will vary depending upon the specific structure of the payment adjustment; these payment adjustments can be different in S. 1 and the House bill. Of course, the actual benefit accruing to an individual provider or physician will depend upon a myriad of unique circumstances;
- to some extent, the provisions increasing payments to rural providers that are contained in S. 1 become effective at a later date or on a longer phased-in basis than the comparable provisions contained in the House bill;
- S. 1 partially finances the proposed prescription drug benefit through freezing certain durable medical equipment (DME) fee schedules as well as extending certain user fees imposed by the U.S. Customs Service (Section 614). The House bill 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 with other payment changes that increase Medicare payments to particular subsets of providers.
- Both bills increase beneficiary cost-sharing amounts in traditional Medicare. 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. In the House bill, beneficiaries' deductibles would be increased annually as well, but the increase would not be based on the CPI-U. Rather the deductible amount would be increased by the same percentage amount traditionally used to increase the Part B premium. Specifically, 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) would be used as the update. S-1 establishes beneficiary coinsurance and deductible requirements for clinical laboratory services; the House bill 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.
- The House bill provides for improved coverage of preventive services, including an initial preventive examination and waives the deductible for certain cancer screening tests.

Table 1. Fee-for-Service Payment Adjustments

Provision	S. 1	H.R. 2473
RURAL PROVISIONS		
Equalize standard rate used in operating inpatient prospective payment system (IPSS)	**Section 401.** Phase-in one-half difference in last three quarters of FY2004. Provides large urban amount for all hospitals in FY2005.	**Section 402.** Pays large urban amount to all hospitals starting in FY2004.
Revise labor- related share in operating IPSS that is adjusted to reflect area wage differences	**Section 402.** Decrease labor-related share for hospitals in low value wage index areas. Change from 71.1% to 68% for FY2004 and subsequently.	**Section 416.** Decreases labor-related share for hospitals from 71.1% to 62% for FY2004 and subsequently.
Low-volume adjustment for eligible IPPS hospitals	**Section 403.** Provides as much as a 25% graduated payment amount for hospitals with up to 2,000 total discharges over 3-year period that have higher costs associated with lower volume starting in FY2005.	No provision.
Equalize disproportionate share hospital adjustment (DSH) to increase DSH payments to small urban and rural hospitals	**Section 404.** Formula establishing DSH adjustment for large urban hospitals applied to all hospitals on or after FY2004.	**Section 401.** DSH formula for large urban hospitals applied to other hospitals. DSH adjustment capped at 10% for all these hospitals except rural referral centers (RRCs)
Changes to Critical Access Hospital (CAH) program	**Section 405.** Increases bed limit for CAHs to 25; removes 35-mile limit for cost-based reimbursement of CAH ambulances; permits periodic interim payments (PIP); clarifies physician billing arrangement; permits payment for additional on-call emergency room providers; extends lapsed authorization and also changes existing grant program for rural hospitals and states; and excludes CAH hospital wage data from IPPS wage index.	**Section 405.** Permits seasonal adjustment of up to five beds and includes the other Senate provisions except does not exclude CAH data from IPPS wage index. Smaller authorizations for existing grant programs. **Section 403.** Establishes essential hospital as part of CAH definition.
Existing hospital outpatient department (HOPD) hold-harmless provisions extended and expanded. Hold-harmless provisions insure that payments under new HOPD prospective payment system (PPS) are not lower than they would have been under prior payment system.	**Section 424.** Extends existing HOPD hold-harmless provisions until 2006 for small rural hospitals. Establishes comparable hold-harmless provisions for sole community hospitals (SCHs) for 2006.	**Section 407.** Extends hold-harmless provisions until 2006 for small rural hospitals.

Provision	S. 1	H.R. 2473
Missing cost reports for sole community hospitals (SCHs)	No provision.	**Section 414.** Otherwise qualified hospital can be SCH if missing cost report data. Must have data from one of the relevant years.
Increased HOPD payments for rural hospitals	**Section 425.** Increase HOPD fee schedule amounts by 5% for 2005-2008; these increases are not included in hold-harmless calculation mentioned previously.	No provision.
Increase ground ambulance fees	**Section 426.** Provides a 5% increase for services provided in rural area (or rural census tract) from January 1, 2005 though December 31, 2007.	**Section 410.** Increase in base rate of fee schedule for eligible rural providers with low-volume of service. Additional payments may be made for providers in frontier areas.
Air ambulance	**Section 427.** Expands definition of medically necessary covered air ambulance services.	No provision.
Rural clinic reimbursement	**Section 429.** Establishes $80.00 as per visit upper payment limit for 2005. Uses medical economic index (MEI) for primary care to update limit in subsequent years.	No provision.
Exclusions from skilled nursing facility (SNF) prospective payment system (PPS)	**Section 430.** Excludes rural health clinic (RHC) and federally qualified health clinic (FQHC) clinic visits as well as CAH joint venture services from SNF-PPS.	**Section 408.** Limits exclusion to RHC and FQHC clinic visit.
Increase in home health payments for rural providers	**Section 451.** 5% increase in rural home health payments 2004-2006.	**Section 411.** 5% increase for home health services in rural areas in 2004 and 2005.
Safe harbor for collaborative efforts	No provision.	**Section 412.** Anti-kickback exception for certain arrangements with health care professionals and health centers that are deemed to protect a professional's independence regarding the provision of medically appropriate treatment.
Clinical diagnostic laboratory tests in a sole community hospital (SCH)	**Section 428.** SCHs would receive reasonable cost reimbursement for tests in 2005 and 2006.	No provision.

Provision	S. 1	H.R. 2473
Hospital loan program for rural entities	**Section 629.** Establishes capital infrastructure loan program.	No provision.
HOSPICE		
Additional hospice services provided under arrangement	**Section 406.** Permits core hospice services to be provided under arrangement.	No provision.
Allow nurse practitioner and others to be attending physicians	**Section 407.** Allows nurse practitioners (NPs) and physician assistants to act as attending physician for hospice patients in certain circumstances.	**Section 409.** Permits NPs to act as attending physicians in certain circumstances.
Consultative physician services under certain circumstances.	No provision.	**Section 512.** Provides payment for consultative services provided by hospice physicians to terminally ill beneficiaries who have not elected the hospice benefit.
HOSPITALS		
Reduction in inpatient prospective payment system (IPPS) operating update	No provision.	**Section 501.** Update would be reduced to market basket (MB)-0.4 percentage points for FY2004-FY2007.
Payments to hospitals in Puerto Rico (PR)	**Section 409.** Bases IPPS payments to PR hospitals on 100% of federal rate from FY2004-FY2009.	**Section 503.** Increases national share of standardized amount on phased-in basis to 75% national/25% PR during FY2006.
Extension of direct payment for certain hospital-based pathology services	**Section 436.** Reestablishes direct payment for certain hospital-based pathology services during 2005.	**Section 724.** Similar provision for inpatient and outpatient services provided on or after January 1, 2001 and before January 1, 2006. (Section may be renumbered as 734.
GAO study on appropriateness of hospital payments	**Section 413.** Requires GAO study on need for geographic adjustments to reflect legitimate differences in hospital costs within 18 months of enactment.	No provision.
Recognition of new medical technologies in IPPS	No provision.	**Section 502.** Mandates changes to existing process to direct additional payments to hospitals.

Provision	S. 1	H.R. 2473
Wage index adjustment for IPPS hospitals	No provision.	**Section 504.** Adjusts hospital's wage index if more than 10% of employees commute from a higher wage index area.
Loan program for certain cancer hospitals in selected states	**Section 608.** Establishes loan program for certain cancer hospitals in states with populations less than 3 million.	No provision.
Change in self-referral exception for specialty hospitals	**Section 453.** Limits exception to self-referral prohibition to acute hospitals offering spectrum of services or specialty hospitals that were substantially complete by June 12, 2003.	**Section 505.** Requires MedPAC report on specialty hospitals examining the extent of self-referrals, quality of care, impact on acute general hospitals as well as differences in Medicaid utilization and uncompensated care provided. Requires the Secretary to submit the report and recommendations to Congress within 1 year of enactment.
More frequent updates to hospital market basket	No provision.	**Section 404.** Directs Secretary to establish more frequent updates to hospital market basket (MB).
Establishment of essential hospital as new type of CAH	No provision.	**Section 403.** Establishes essential hospital as part of CAH definition.
TEACHING HOSPITALS		
Payment for existing residencies in nonhospital settings	**Section 411.** Establishes payment for resident training in nonhospital providers. Excludes dentists and podiatrists from 3-year rolling average used to calculate graduate medical education payments.	No provision.
Medicare payments for psychologists	**Section 408.** Establishes clinical psychologist training as allied health reimbursement.	No provision.
Medicare graduate medical education payments for 2-year geriatric fellowships	**Section 410.** Provides for payment of 2-year geriatric fellowships (rather than 1-year fellowships necessary for certification).	No provision.
Extension of update limit on direct graduate medical education reimbursement of high cost residents	No provision.	**Section 711.** Hospitals with per resident amounts above 140% of the locality adjusted national average would not get increases from FY2004-2007.

Provision	S. 1	H.R. 2473
Redistribution of resident positions	No provision.	**Section 406.** Redistributes unused resident positions from those hospitals under existing cap. Priority given to hospitals in small urban and rural areas.
SKILLED NURSING FACILITIES (SNFs) AND SERVICES PROVIDED TO SNF RESIDENTS		
Increases in SNF payments for residents with AIDs	No provision.	**Section 511.** Increases SNF payment for resident with AIDS by 128% beginning in FY2004.
Exclusion of services provided by certain rural entities from SNF PPS (also included in table as rural provision)	**Section 430.** Excludes RHC and FQHC clinic visits and certain CAH joint ventured services from SNF-PPS	**Section 408.** Limits the exclusion to RHC and FQHC clinic visits.
One-year moratorium on therapy caps	No provision.	**Section 624.** Mandated therapy cap would be suspended in 2004.
PAYMENTS FOR CURRENTLY COVERED OUTPATIENT DRUGS AND SERVICES		
Payment amounts	**Section 433(a).** Existing drugs paid at 85% of average wholesale price (AWP) as of April 1, 2003 which would be updated in subsequent years by increases in the CPI for medical care. The Secretary to determine market price. If average market price (AMP) differs from AWP, then AMP would be paid, subject to 15% dampening effect. Requires manufacturers to provide information on expected price of new drug.	**Section 621(a)**. From 2004-2006 payment is no less than 95% of AWP or transition percentage. The transition percentage for sole source drugs is 83%-71% of AWP from 2004-06; multisource drugs is 81.5%-68% of AWP from 2004-2006; generic drugs is 46% from 2004-2006. Existing threshold for separate ambulatory payment classification (APC) payment as higher cost drug would be dropped from $150 to $50.
Payment for blood clotting factors	**Section 433(b).** Establishes separate payment for blood clotting factors. Directs Secretary to review GAO report on too high current payments. Budget-neutrality requirement for 2004. Payment updated by CPI for medical care.	**Section 303(f)**. Requires MedPAC recommendations in 2004 annual report.
Home infusion and inhalation drugs	**Section 433(b).** Separate payment would be made for these drugs beginning January 1, 2004. Some restrictions apply.	**Section 602(b).** Requires GAO study on adequacy of payments for inhalation therapy, due not later than May 1, 2004.

Provision	S. 1	H.R. 2473
Pharmacy dispensing fee	**Section 433(b).** Authorizes dispensing fees for certain covered drugs.	No provision.
Discarded chemotherapy drugs	**Section 433(b).** Permits payments for discarded cancer drugs in certain circumstances.	No provision.
Transitional pass-through payments for new drugs	**Section 437.** Requires that pass-through payments be calculated as if legislation was not passed. Requires GAO to report on issue.	No provision.
Functional equivalence standard used to establish eligibility for additional transitional pass-through payments for new drugs in HOPD-PPS	**Section 438.** Secretary would not be allowed to issue regulations or apply standard.	**Section 621(c)**. Secretary would be allowed to issue regulations and apply standard. Would not be able to be applied prior to June 13, 2003.
Coverage of clinical trials	**Section 439.** Covers routine costs of clinical trials in certain instances.	**Section 723(b).** Same provision.
Improved payment for certain mammography services	No provision.	**Section 614.** Codifies existing exclusion from hospital outpatient prospective payment system of screening mammography services. Expands exclusion to unilateral and bilateral diagnostic mammography.
Special payment for brachytherapy, an advanced cancer therapy where radioactive seeds or sources are placed near the tumor itself.	No provision.	**Section 621(b)**. From 2004-2006, Medicare payments are charges adjusted to cost. Additional brachytherapy seeds would have separate ambulatory payment categories (APCs) created. Requires GAO report by 2005.
Hospital acquisition cost study	No provision.	**Section 621(d)**. Requires Secretary to study hospital acquisition costs for drugs greater than $50 in representative sample of hospitals.
AMBULATORY SURGICAL CENTERS		
Reduction in update for ambulatory surgical centers (ASCs)	No provision.	**Section 625.** Establishes ASC update as the CPI-U minus two percentage points (but above zero) for 2004-2008

Provision	S. 1	H.R. 2473
AMBULANCE		
Changes to ambulance fee schedule	No provision.	**Section 622.** Modifies current law payment methodology to incorporate regional fee schedule amounts. By 2010, fee schedule would be based totally on national rates. Increases payments by 25% of the otherwise established payment amount for trips longer than 50 miles beginning in January 1, 2004 through December 31, 2008. GAO study is required.
PAYMENTS FOR RENAL DIALYSIS SERVICES		
Temporary increase in composite rate for end stage renal disease (ESRD) services	**Section 423.** Provides for 1.6% increase in composite rate for 2005 and 2006.	**Section 623(c).** Provides for 1.6% increase in composite rate for 2004.
Composite rate increase for administration of drugs related to ESRD services.	**Section 433(b).** ESRD composite rate increased by 0.05% in 2005 including temporary payment increase of earlier section. ESRD composite rate increased in 2006 by 0.05% without 1.6% temporary increase in Section 423.	No provision.
Codifies existing alternative service delivery demonstration project for providing ESRD services	No provision.	**Section 623(a)**. Requires establishment of advisory board for demonstration of ESRD alternative delivery model.
Composite rate exception for pediatric facilities	No provision.	**Section 623(b)**. Restores composite rate exception for pediatric facilities.
PHYSICIANS		
Floor on geographic adjustments	**Section 421.** Raise work geographic adjustment to .980 for 2004. Raise work geographic adjustment to 1.0 in 2005, 2006, 2007. Practice expense and malpractice adjustments raised to 1.0 for services in CY2005-CY2008.	No provision.
Update to conversion factor	No provision.	**Section 601.** Update to conversion factor could not be less than 1.5% in CY2004 and CY2005.

Provision	S. 1	H.R. 2473
Change sustainable growth rate (SGR) calculation	No provision.	**Section 601.** Incorporates 10-year rolling average calculation of GDP.
Medicare Incentive Payments	**Section 422.** Specifies that the Secretary responsible for identifying physicians who are eligible for existing 10% payment increase.	**Section 417.** Provides a 5% payment increase to physicians in certain areas with low ratios of physicians to beneficiaries.
Adjustment to physician relative values to incorporate survey data collected by outside entities	**Section 433(b).** Incorporates oncology survey data into practice expense adjustment; payment adjustment for multiple chemotherapy doses in a day; non-physician workpool not affected.	**Section 303(a)**. Includes general instruction to include specialty data collected by outside entities. No specific reference to oncology. Budget neutrality requirement waived for 2005. Same non-physician workpool provision.
Use of competitive contracting program to provide prescription drugs to physicians	No provision.	**Section 303(b)**. Establishes competitive acquisition program for oncology drugs in 2005 and nononcology drugs in 2006. Payments based on bid prices which can be adjusted for rebates and discounts. Other provisions apply.
Payments for radiopharmaceuticals	No provision.	**Section 303(c)**. Extends existing payment methods for radiopharmaceuticals.
GAO Study	**Section 445.** Requires GAO report on geographic difference in physician payments within 1 year of enactment.	**Section 413.** Same provision.
GAO and IOM Study	No provision.	**Section 602.** GAO study on beneficiary access. IOM study on adequacy of supply of physicians and specialists.
MedPAC Report	No provision.	**Section 603.** Requires MedPAC report on refinements to practice expense component.

Provision	S. 1	H.R. 2473
DURABLE MEDICAL EQUIPMENT (DME)		
Certain DME Fee schedules frozen	**Section 431.** No increase in certain DME fee schedules from 2004-2010. Class III medical devices would be exempt. Prosthetics, prosthetic devices, custom orthodics would be updated by CPI. Quality assurance program initiated.	No provision.
Competitive acquisition demonstration project for DME	No provision.	**Section 302.** Establishes demonstration project for competitive bidding for DME.
Increase payments for custom made orthotics and shoes for beneficiaries with severe diabetic foot disease	No provision.	**Section 626.** Bases payments for these items as if they are a prosthetic or orthotic device subject to certain limits.
HOME HEALTH		
Increase payments for rural home health providers	**Section 451.** Provides temporary 5% increase in rural home health payments in 2005-2006.	**Section 411.** Provides 5% increase in rural home health payments in FY2004.
Limit effect of reduction in wage index	**Section 452.** Limits effect of any area wage reduction to 3% in FY2005-2006.	No provision.
Reduce update in home health	No provision.	**Section 701.** Changes payment year to calendar year basis. Establishes home health updates as MB minus 0.4 percentage points from 2004-2006.
MedPAC study of home health margins	No provision.	**Section 703.** Requires MedPAC study on home health margins be submitted within 2 years of enactment.

Source: Congressional Research Service.

Table 2. Beneficiary Cost Sharing Changes and Benefit Improvements

Provision	S. 1	H.R. 2473
Deductible and coinsurance for clinical diagnostic laboratory services	**Section 432.** Clinical laboratory tests across all settings subject to beneficiary cost-sharing and deductible.	No provision.
Scheduled annual increases in Part B deductible amount	**Section 434.** Increases deductible from $100 to $125 in 2006; increased by CPI-U in following years	**Section 628.** Increases Part B deductible by the same percentage increase applied to the Part B premium each year starting in 2004.
Establish copayment for home health episodes for certain beneficiaries	No provision.	**Section 702.** Establishes beneficiary copayment for each 60-day episode at 1.5% of the national average payment rate per episode in the year for services in 2004. Absent timely regulatory action, the copayment would be $40.
Waiver of Part B late fee for certain military retirees	**Section 440.** Waives required Part B late fee for certain military retirees.	**Section 627.** Same provision.
Waiver of deductible for colorectal cancer screening tests	No provision.	**Section 614**. Waives deductible for these tests.
Coverage of clinical trials	**Section 439.** Routine costs of clinical trials in certain instances would be covered.	**Section 723(b).** Same provision.
Coverage of an initial preventive examination	No provision.	**Section 611.** Establishes coverage of initial preventative examinations in accordance with U.S. Preventive Services Task Force recommendations within 6 months of beneficiary enrollment in program. Waives Part B cost sharing.
Coverage of cholesterol and blood lipid screening	No provision.	**Section 612.** Establishes coverage under standards determined by the Secretary, but no more than two times per year.

Provision	S. 1	H.R. 2473
Complex and chronic care provisions	**Section 443.** Establishes a 3-year demonstration on complex clinical care management. **Section 444.** Establishes a 5-year demonstration on care coordination under fee-for-service Medicare for certain high-risk beneficiaries.	**Section 721.** Provides care improvement services to certain beneficiaries with chronic conditions. **Section 722.** Provides comparable services to beneficiaries in Medicare Advantage and Enhanced FFS.

Source: Congressional Research Service.