



**Prescription Drug Coverage for Medicare Beneficiaries:
A Side-by-Side Comparison of S. 1 and H.R. 1, and the Conference Agreement
(H.R. 1)**

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for The Henry J. Kaiser Family Foundation**

November 26, 2003

PRESCRIPTION DRUG PROPOSALS IN THE 108th CONGRESS

| | S. 1 as amended and passed in Senate, June 27, 2003 | H.R. 1 as amended and passed in House of Representatives, June 27, 2003 | Conference Agreement for H.R. 1 as passed by House on November 22, 2003 and Senate on November 25, 2003. |
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| Title of Bill | Prescription Drug and Medicare Improvement Act of 2003 | Medicare Prescription Drug and Modernization Act of 2003 | Medicare Prescription Drug, Improvement, and Modernization Act of 2003 |
| General Approach | <p>Voluntary stand-alone drug benefit under Medicare Part D administered by new Center for Medicare Choices in the Department of Health and Human Services (DHHS) and delivered through private risk-bearing entities. Government contracts with a private, non-risk-bearing plan that administers benefit (so-called “fallback”) in regions with fewer than two private stand-alone drug plans. Drug benefits integrated with enhanced Part A and B benefits provided by private plans under new Medicare Advantage (Part C). All private plans share risk with government for drug benefit. Also provides subsidies for drug coverage to enrollees in qualified retiree plans and qualified state pharmaceutical assistance programs (SPAPs).</p> <p>Interim prescription drug discount card endorsement program (2004-2005) with government-subsidized card accounts for low-income.</p> | <p>Voluntary stand-alone drug benefit under Medicare Part D administered by new Medicare Benefits Administration in the Department of Health and Human Services (DHHS) and delivered through private risk-bearing entities. Also provides subsidies for drug coverage to enrollees in qualified retiree plans. Drug benefits integrated with enhanced Part A and B benefits provided by private plans under Medicare Advantage (Part C) or new Enhanced Fee-for-Service (FFS) plan options (Part E). Establishes competitive government contribution system (FEHBP-style reforms) in 2010 that includes traditional Medicare.</p> <p>Interim prescription drug discount card endorsement program (2004-2005) with government-subsidized card accounts for beneficiaries without other drug coverage.</p> | <p>Voluntary drug benefit under Medicare Part D delivered through private risk-bearing entities under contract with the Department of Health and Human Services (DHHS). Drug benefits provided through stand-alone prescription drug plans (PDPs) or comprehensive plans, integrated with enhanced Part A and B benefits, under Part C (renamed Medicare Advantage (MA)). Government fallback plan authorized for areas without sufficient plan choices. Also provides subsidies for drug coverage to enrollees in qualified retiree plans. Establishes a demonstration for a Medicare competitive government contribution system (Comparative Cost Adjustment Program) beginning in 2010 that includes traditional Medicare.</p> <p>Interim prescription drug discount card program (2004-2005) with subsidies for the low-income who are not eligible for Medicaid.</p> |
| Effective Date | 1/1/2006 for new Part D benefit | 1/1/2006 for new Part D benefit | 1/1/2006 for Part D benefit. |
| Eligibility | Individuals entitled to Part A and enrolled in Part B may enroll in Part D, unless they receive full Medicaid benefits. | Individuals entitled to Part A or enrolled in Part B may enroll in Part D. | Individuals entitled to Part A or enrolled in Part B may enroll in Part D. |
| Benefit Package | All Part D Medicare Prescription Drug Plans (PDPs) or Medicare Advantage plans must offer the standard benefit or its actuarial equivalent. Part D and Medicare Advantage plans (except Medical Savings Accounts plans) may also offer richer drug benefits in separate | All Part D Medicare prescription drug plans (PDPs), Medicare Advantage coordinated care plans, and FFS plans must offer at least the standard drug benefit or its actuarial equivalent. Plans may offer richer coverage in lieu of standard coverage. | All Part D Medicare PDPs and MA plans must offer at least the standard drug coverage or its actuarial equivalent (called “basic” coverage). Actuarially equivalent plans may not have a deductible larger than the standard deductible, and the out-of-pocket threshold must be the same. |

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| | plan. | | PDP and MA plan sponsors may also offer separate plans with richer coverage. |
| Monthly Premium | <p>Part D standard coverage – CBO estimate of \$34.00 on average in first year (2006) and increasing to \$62.00 in 2013 – based on enrollee's choice of plan. The penalty for delayed enrollment would be an amount determined by the Administrator to be actuarially sound for each 12-month period not enrolled.</p> <p>In Medicare Advantage, drug premium calculated in same way but may be offset by savings from other benefits.</p> <p>In general, Part D premiums are deducted from the beneficiary's monthly Social Security check.</p> | <p>Part D standard coverage – CBO estimate of \$35.50 on average in first year (2006) and increasing to \$56.00 in 2013– based on enrollee's choice of plan. Plans could adjust premiums for late enrollment for individuals who did not maintain continuous coverage to the extent of the additional actuarial risk involved.</p> <p>In Medicare Advantage and EFFS, premium calculated in same way but may be offset by savings from other benefits.</p> <p>At enrollee option, Part D premiums may be deducted from beneficiary's Social Security check or paid through an electronic funds transfer.</p> | <p>Part D standard coverage – CBO estimate of \$35 per month on average in first year (2006) and increasing to \$58 per month in 2013 – based on enrollee's choice of plan. For late enrollment, the premium amount is increased by the greater of an amount the Secretary determines is actuarially sound or one percent for each month the individual did not have creditable coverage after the end of the individual's initial enrollment period.</p> <p>For MA plans, the drug premium is calculated in the same way, but may be offset by savings from Part A and B benefits.</p> <p>At enrollee option, Part D premiums may be paid directly to the PDP or MA plan, deducted from beneficiary's Social Security check, or paid through an electronic funds transfer.</p> |
| Deductible | \$275 (indexed to growth in per capita drug spending by Medicare beneficiaries). | \$250 (indexed to growth in per capita drug spending by Medicare beneficiaries). | \$250 in 2006 (indexed to grow annually by the growth in per capita Part D drug spending by Medicare beneficiaries). Estimated to be \$445 in 2013. |
| Cost-Sharing | 50% up to initial coverage limit of \$4,500; 100% between initial limit and stop-loss threshold; 10% above stop-loss threshold. (Thresholds are indexed.) | 20% up to initial coverage limit of \$2,000; 100% between initial limit and stop-loss; no coinsurance above stop-loss threshold. (Thresholds are indexed.) | 25% up to initial coverage limit (\$2,250 in 2006 increasing to an estimated \$4,000 in 2013), or actuarially equivalent copayments. 100% of negotiated price between initial limit and stop-loss; <u>greater</u> of \$2 generics/\$5 brand copays or 5% coinsurance above stop-loss threshold. (Thresholds are indexed.) |
| Stop-Loss Threshold Applied to Out-of-Pocket | \$3,700 (indexed). After reaching threshold, 90% reimbursement. Excludes payments from other private insurance such as employer retiree health coverage. | \$3,500 (indexed). After reaching threshold, 100% reimbursement. Excludes payments from other private insurance such as employer retiree health | \$3,600 in 2006 (\$5,100 in total Rx spending), increasing to \$6,400 (\$9,066 in total Rx spending) in 2013. After reaching threshold, enrollee pays <u>greater</u> of \$2 |

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| Spending | | coverage. Special rules for qualified employer plans (see below). | generics/\$5 brand drugs (indexed as above), or 5% coinsurance. Excludes cost of drugs not on (or treated as being on) plan's formulary. Also excludes payments from other private insurance, such as employer retiree health coverage. |
| Income-Related Stop-Loss Threshold | No provision. | Income-related stop-loss threshold for enrollees with incomes above \$60,000/individuals and \$120,000/couples. Treasury Secretary provides income information to HHS Secretary, who then discloses applicable out-of-pocket thresholds to drug plan sponsors. | No provision. |
| Government Subsidies for General Medicare Population | About 70% of standard drug benefit costs provided through direct premium subsidies and reinsurance. Plans would receive reinsurance for 80% of actual net costs above stop-loss threshold for standard drug coverage (except qualified state pharmaceutical assistance plans would receive reinsurance of 65%). | Direct premium subsidies of 43% of national average premium for standard coverage; reinsurance of 30% of standard benefits in aggregate. Reinsurance payments of 20% for standard benefits \$1,000-\$2,000; 80% above stop-loss. | Overall federal subsidy is 74.5% of the basic coverage, provided through direct premium subsidies and reinsurance. Plans receive reinsurance for 80% of benefit costs (including dispensing costs but excluding administrative costs) above stop-loss threshold for standard drug coverage. |
| Government Subsidies for Low-Income Population—Premiums | Enrollees with incomes under 135% of poverty (including QMB, SLMB, QI, ⁱ as well as others who do not meet asset test) would receive a full premium subsidy for standard drug coverage up to the national weighted average premium (or lowest-cost plan if none was below the national average). Beneficiaries with incomes between 135% and 160% of poverty (no asset test) would receive additional premium subsidies determined on a linear sliding scale. | Enrollees with incomes up to 135% of poverty and who meet asset test would receive a full premium subsidy for standard drug coverage. Those with incomes between 135% and 150% of poverty and who meet the asset test would receive additional premium subsidies on a sliding scale. The asset test would be \$6,000 single/\$9,000 couple in 2006 and would be indexed to increase annually with inflation. | All Medicaid full benefit dual eligibles (regardless of income and assets) are eligible for a full premium subsidy. Other enrollees with incomes below 135% of poverty and who meet asset test receive a full premium subsidy. The subsidy is equal to the weighted average premium for basic benefits available in the region (but in no case less than the lowest-cost plan available). The asset test is \$6,000 single/\$9,000 couple in 2006 (indexed to increase annually with inflation). (The government will also subsidize most of any late enrollment penalties.) All other beneficiaries with incomes below 150% of poverty and who meet an asset test of \$10,000 single/\$20,000 couple (indexed to inflation) receive premium subsidies on a |

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| | | | sliding scale. |
| Government Subsidies for Low-Income Population—Cost-Sharing | <p>QMBs would have no deductible; pay 2.5% coinsurance up to the initial limit, then 5% coinsurance to the stop-loss (i.e., the “donut hole”) and 2.5% above the stop-loss. SLMBs and QIs would have no deductible, pay 5% coinsurance up to the initial limit, then 10% up to the stop-loss (i.e., the “donut hole”) and 2.5% above the stop-loss.</p> <p>Beginning in 2009, the asset test for drug cost-sharing subsidies for individuals eligible for QMB, SLMB, and QI Part D benefits would be increased to \$10,000 single/\$20,000 couple and indexed in subsequent years. All other Part D enrollees with incomes below 160% of poverty would pay a \$50 deductible (indexed); 10% coinsurance to the initial limit, then 20% to the stop-loss (i.e., “the donut hole”) and 10% above the stop-loss.</p> | <p>Enrollees with incomes up to 135% of poverty who meet an asset test (as above) would have no deductible and receive cost-sharing subsidies so that they pay no more than \$2 for generics and \$5 for brand drugs up to the initial coverage limit. Copayment amounts would be indexed to growth in per capita drug spending by Medicare beneficiaries. No low-income subsidies for costs of drugs between the initial limit and the stop-loss threshold (i.e., the “donut hole”).</p> | <p>Medicaid full benefit dual eligibles with incomes up to 100% of poverty will have no deductible and have copays of \$1 generics/\$3 brand (indexed to CPI), up to the out-of-pocket threshold, then no copay requirements. Medicaid full benefit dual eligible enrollees with incomes above 100% of poverty will have cost-sharing subsidies based on their income category, as described below. However, institutionalized dual eligibles will have no cost-sharing requirements. Enrollees who are not full duals with incomes below 135% of poverty and who meet the asset test as above (i.e., \$6,000/\$9,000) will have no deductible, pay no more than \$2 generics/\$5 for brand drugs, and have no cost-sharing above the out-of-pocket threshold. Other enrollees with incomes below 150% of poverty who meet the asset test as above (i.e., \$10,000/\$20,000) will pay a \$50 annual deductible, 15% coinsurance up to the stop-loss threshold and <u>greater</u> of 5% or \$2 generic/\$5 brand above the out-of-pocket threshold. The \$2 and \$5 copayment amounts will be indexed to grow annually by the growth in per capita Part D drug spending by Medicare beneficiaries.</p> |
| Treatment of Dual Eligibles | <p>Medicare beneficiaries who receive full benefits, including prescription drugs, under Medicaid are not eligible for drug coverage under Medicare Part D. These beneficiaries would continue to receive drug coverage through Medicaid, according to each state’s Medicaid plan.</p> | <p>All individuals entitled under Part A or enrolled in Part B, including those who are enrolled in Medicaid would be eligible to enroll in Medicare Part D (State government's obligation would be phased out). States would maintain Medicaid benefits as a wrap-around to Medicare benefits (at state option); states could require that these persons elect Part D</p> | <p>States will no longer be able to receive federal Medicaid matching funds to cover Part D copayments or drugs excluded from Part D coverage due to the application of a Part D plan formulary for dual eligibles. State Medicaid programs can receive federal matching funds to provide coverage for classes of drugs not covered by Part D.</p> |

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| | | drug coverage. | <p>Medicaid full benefit dual eligibles will be eligible for Medicare Part D and will be considered eligible for the low-income subsidies described above. QMBs, SLMBs, and QIs would be eligible for Part D and may be deemed eligible for low-income premium and cost-sharing subsidies if the Secretary determines the state applies substantially the same eligibility requirements as provided for Part D.</p> <p>States will be required to make a payment to the federal government each month equal to the product of 1) a “take back” factor, which is set at 90% for 2006 and phased down to 75% for 2015 and later years; 2) the number of dual eligibles enrolled in full Medicaid coverage in that month; and 3) a per capita amount designed to approximate the amount a state would have spent each month on Medicaid prescription drugs per full benefit dual eligible in the absence of the Medicare bill. This “per capita amount” is based on a state’s per capita Medicaid spending on Part D covered prescription drugs for full dual eligibles in 2003, trended forward through 2006 by the growth in national per capita prescription drug expenditures and in 2007 and later years by per capita growth in Part D spending.</p> |

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| Administration of the Low-Income Subsidy | State Medicaid programs are required to evaluate eligibility for low-income subsidies using presumptive eligibility procedures, with states receiving enhanced matching rate for associated administrative costs. States must conduct eligibility determinations and enrollment at all Social Security field offices. Individuals determined to be eligible for Medicare cost-sharing assistance would be enrolled for such benefits under Medicaid. Administrator (Center for Medicare Choices) informs prescription drug plans of subsidy eligibility and level. Plans provide the subsidy and the Administrator reimburses the plans for their costs. | Eligibility for low-income subsidy program determined by state Medicaid program with states receiving enhanced matching rate for associated administrative costs, at an FMAP phasing up to 100% by 2019. Also, eligibility determinations by SSA, with additional funds to cover new administrative costs. Administrator (Medicare Benefits Administration) informs prescription drug plans of subsidy eligibility and level. Plans provide the subsidy, and the Administrator reimburses them for their costs. | Eligibility for low-income subsidies will be determined by state Medicaid programs, with states receiving their regular matching rate for associated administrative costs. Eligibility determinations may also be made by SSA, with additional funds authorized to cover new administrative costs. Determinations effective for up to one year. A model, simplified application form will be developed to allow for beneficiary attestation of assets (accompanied by recent statements, if any, from financial institutions), subject to penalty for perjury. The Secretary will inform PDPs of subsidy eligibility and level. Plans provide the subsidy, and the Secretary reimburses them for their costs. |
| Role of Private Plans/Traditional Medicare Role of Fallback plan | Benefits provided through private, risk-bearing plans (shared risk with government through risk corridors in first years and reinsurance). Government contracts with private non-risk-bearing entity to provide coverage in areas with fewer than 2 private stand-alone PDPs. | Benefits provided through private, risk-bearing plans (shared risk with government through reinsurance). Administrator authorized to increase government risk as necessary (but not full risk) to guarantee 2 plan options (at least one stand-alone drug plan) in each area. | Benefits provided through private, risk-bearing plans (shared risk with government through risk corridors in first years and reinsurance). Provides for limited risk plans if necessary to guarantee at least two plan options offered by different entities (at least one stand-alone drug plan) in each area. Secretary contracts with private entities for fallback plans for areas within regions failing to meet minimum plan access standard. Fallback plans must offer standard benefit, and accept management fees tied to performance risk. Fallback plan enrollee premiums equal to 25.5% of estimated average per capita costs (including administrative expenses) of providing drug benefits in region. Prohibits a national fallback plan. |
| Payments to Drug Plan | Part D - government pays plans an amount equal to the monthly approved | Part D - government pays plans an amount equal to the monthly approved premium, | Part D - plans receives an amount equal to the monthly-approved bid, adjusted for |

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| Sponsors | <p>premium, adjusted for risk and geographic price variations, from a combination of government contribution and enrollee premium. Government shares risk with drug plans through reinsurance (80% of allowable drug costs exceeding the catastrophic threshold) and risk corridors. Drug plans would be required to assume more but not total risk over time.</p> <p>Medicare Advantage plans are paid their premium amounts for drug coverage in a similar manner. The same reinsurance, risk corridor, stabilization fund, and administrative incentive provisions apply.</p> | <p>adjusted for risk. Payment is combination of government premium subsidy and enrollee share of premium. Government also provides reinsurance of 20% for costs \$1,000-\$2,000 and 80% above stop-loss.</p> <p>Medicare Advantage and EFFS plans receive payments for drug coverage in a similar manner and also receive reinsurance payments.</p> | <p>risk and geographic price variations. Payment is combination of government contribution and enrollee premium. Government shares risk with drug plans through reinsurance (80% of allowable drug costs exceeding the stop-loss threshold) and risk corridors. Drug plans would be required to assume more, but not total, risk over time.</p> <p>Medicare Advantage plans receive payments for drug coverage in a similar manner and also receive reinsurance payments.</p> |
| Covered Drugs | <p>Drugs, biological products and insulin (including associated syringes and medical supplies as defined by the Administrator) that are covered under Medicaid and vaccines licensed under Section 351 of the Public Health Service Act. Includes coverage for any use of a covered outpatient drug for a medically accepted indication, as defined under Medicaid.</p> | <p>Drugs, biological products and insulin (and medical supplies associated with the injection of insulin as defined by the Secretary) that are covered under Medicaid and vaccines licensed under Section 351 of the Public Health Service Act. Includes coverage for any use of a covered outpatient drug for a medically accepted indication, as defined under Medicaid.</p> | <p>Drugs, biological products and insulin (and medical supplies associated with the injection of insulin as defined by the Secretary) that may be dispensed only by prescription and that are covered under Medicaid and vaccines licensed under Section 351 of the Public Health Service Act. Includes coverage for any use of a covered outpatient drug for a medically accepted indication, as defined under Medicaid.</p> |
| Drugs Excluded from Coverage | <p>Excluded would be drugs covered under Medicare Parts A or B (unless no benefits are payable), and those in categories that may be excluded under Medicaid (i.e., weight loss or gain, fertility, cosmetic or hair growth, cough or cold relief, vitamins and minerals, non-prescription drugs, barbituates, and benzodiazepines) except for smoking cessation agents. Drugs not covered because of a plan's formulary would be excluded if not</p> | <p>Excluded would be drugs for which benefits are payable under Medicare Parts A or B, and those in categories that may be excluded under Medicaid (i.e., weight loss or gain, fertility, cosmetic or hair growth, cough or cold relief, vitamins and minerals, non-prescription drugs, barbituates, and benzodiazepines) except for smoking cessation agents. Drugs not covered because of a plan's formulary would be excluded if not successfully</p> | <p>Excluded would be drugs for which benefits are payable under Medicare Parts A or B, and those in categories that may be excluded under Medicaid (i.e., weight loss or gain, fertility, cosmetic or hair growth, cough or cold relief, vitamins and minerals, non-prescription drugs, barbituates, and benzodiazepines) except for smoking cessation agents. Drugs not meeting the Medicare definition of reasonable and necessary, or not</p> |

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| | successfully appealed. Drugs not meeting the Medicare definition of reasonable and necessary, or not prescribed according to requirements, could be excluded from coverage, but determinations would be subject to appeal. | appealed. Drugs not meeting the Medicare definition of reasonable and necessary, or not prescribed according to requirements, could be excluded from coverage, but determinations would be subject to appeal. | prescribed according to Part D or plan requirements, could be excluded from coverage, but determinations would be subject to reconsideration and appeal. |
| Formularies | Plans may have a formulary so long as the formulary meets standards. Formularies must be developed by a pharmacy and therapeutic (P&T) committee that includes at least one academic expert, one practicing physician and one practicing pharmacist, all with expertise in the care of elderly or disabled; a majority of P&T committee must be practicing physicians or pharmacists; formulary must include drugs within each therapeutic category and class (as defined by the Administrator using certain compendia and other recognized sources); decisions must be based on the strength of scientific evidence and standards of practice; the committee must have procedures to educate providers concerning the formulary; and appropriate notice must be given to enrollees, pharmacists, and physicians before a drug is removed from the formulary. | Plans may have a formulary so long as the formulary meets standards. Formularies must be developed by a P&T committee that includes at least one practicing physician and one practicing pharmacist independent and free of conflict with respect to the committee, both with expertise in the care of elderly or disabled; the formulary must include drugs within each therapeutic category and class; decisions must be based on the strength of scientific evidence and standards of practice; the committee must have procedures to educate providers and enrollees concerning the formulary; and appropriate notice must be given to enrollees and physicians before a drug is removed from the formulary or the tier status of a drug is changed. In defining therapeutic classes, the committee would take into account standards published in the United States Pharmacopeia-Drug Information. | Plans may have a formulary, so long as the formulary meets standards. A formulary must be developed and reviewed by a pharmacy and therapeutic (P&T) committee that includes at least one practicing physician and one practicing pharmacist, each independent and free of conflict with the plan; and with expertise in the care of elderly or disabled; a majority of P&T committee must be practicing physicians or pharmacists. Formulary must include drugs within each therapeutic category and class as defined by the plan; plans may change categories and classes only at the beginning of the plan year except as allowed to account for new drugs or therapeutic uses. The United States Pharmacopeia would develop model categories and classes that may be used by plans. The P&T committee must have procedures to educate enrollees and providers concerning the formulary. Appropriate notice must be made to enrollees, pharmacists, pharmacies, and physicians before a drug is removed from the formulary or the tier status is changed. |
| Access to Drugs Not on Formulary or Preferred Drug List | Beneficiaries could appeal for coverage of non-formulary drugs if the prescribing physician determines that the formulary drug is not effective for the patient or has significant adverse effects for the patient. In plans with tiered cost-sharing, | Beneficiaries could appeal for coverage of non-formulary drugs, or to have non-preferred formulary drugs be covered as preferred drugs, if the prescribing physician determines that the formulary drug either is not effective for the patient | Enrollees could appeal for coverage of non-formulary drugs only if the prescribing physician determines that all drugs on any tier of the formulary for treatment of the same condition would not be as effective for the patient, or would |

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| | enrollees may request that non-preferred drugs be covered as preferred drugs if the prescribing provider determines that the preferred drug is not effective or has adverse effects on the patient. | or has significant adverse effects for the patient, or both. | have significant adverse effects for the patient, or both. In plans with tiered cost-sharing, plans must have an exceptions process to allow an enrollee to request a non-preferred drug to be covered as a preferred drug if the prescribing physician determines that the preferred drug either would not be as effective for the patient, or would significant adverse effects for the patient, or both. Denials are subject to appeal by the enrollee. |
| Drug Pricing | Plans would negotiate drug prices and must make the negotiated price available to enrollees regardless of whether benefits are payable. Negotiated price is defined to include all discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations. Drug plan sponsors must provide that each pharmacy or dispenser of a covered drug inform the enrollee at the time of purchase of any differential between the price of the drug and the price of the lowest-cost generic equivalent. Drug prices negotiated for Part D (by a PDP, MA plan, or qualified retiree plan) would not be applicable to Medicaid “best price” provisions. If a Medicaid plan uses prices negotiated by a Medicare PDP to provide Medicaid assistance, Medicaid rebate provisions would not apply. | Plans would negotiate prices with manufacturers and suppliers of covered drugs. Enrollees must have access to their plan’s negotiated prices even if no benefits are paid. Each plan must disclose to the Administrator the extent to which discounts or rebates or other remuneration or price concessions made available to the plan sponsor or organization by a manufacturer are passed through to enrollees through pharmacies and other dispensers or otherwise. The Administrator would have to keep this information confidential. PDP sponsors must provide that each pharmacy or dispenser of a covered drug inform the enrollee at the time of purchase of any differential between the price of the drug and the price of the lowest-cost generic equivalent. Drug prices negotiated for Part D (by a PDP, MA or EFFS plan, or qualified retiree plan) would not be applicable to Medicaid “best price” provisions. If a Medicaid plan uses prices negotiated by a Medicare PDP to provide Medicaid assistance, Medicaid rebate provisions would not apply. | Plans would negotiate prices with manufacturers and suppliers of covered drugs. Enrollees must have access to their plan’s negotiated prices even if no benefits are paid. Negotiated prices must take into account negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, and include any dispensing fees. Each plan must disclose to the Secretary the aggregate negotiated price concessions made available by a manufacturer. The Secretary would have to keep this information confidential. Plan sponsors must provide that each pharmacy that dispenses a covered drug inform the enrollee at the time of purchase (or at the time of delivery for mail order) of any differential between the price of the drug and the price of the lowest-cost generic that is therapeutically equivalent and bioequivalent and available at the pharmacy. Drug prices negotiated for Part D (by a PDP, MA or qualified retiree plan) would not be applicable to Medicaid “best price” provisions. |
| Medicaid | Medicaid continues to pay the full cost of | All individuals eligible for Part A and | All individuals eligible for Part A and |

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| <p>Financing</p> <p>providing drug coverage to duals (with usual FMAP) according to each state's Medicaid plan.</p> <p>States that provide a drug benefit under Medicaid that meets minimum standards would receive 100% federal funds for payment of the Part B premium for Medicaid and QMB eligibles with incomes between the SSI threshold and 100% of poverty. The minimum standards would be: meeting all current Medicaid standards for dual enrollees, including nominal cost-sharing; no limit on number of prescriptions; coverage of smoking cessation products; and meeting Part D standards for beneficiary protections.</p> <ul style="list-style-type: none"> ▪ Incentives to Maintain Coverage for Optional Medicaid Provisions ▪ Medicaid Rebate ▪ Best Price Requirements | <p>In states with optional expansions of Medicaid to seniors and/or the disabled with income up to 100% of poverty, the federal government pays 100% (instead of usual FMAP) of Medicare Part A deductible and coinsurance costs for the expansion population. Applies only to states with optional expansions in place as of date of enactment.</p> <p>If states elect to use prices negotiated by a PDP to provide Medicaid drug benefits, Medicaid rebate provisions would not apply.</p> <p>Prices negotiated for discount drug card endorsement program or Medicare Part D benefits by PDP, MA, and qualified employer plans would not apply to Medicaid "best price" requirements.</p> | <p>enrolled in Part B are eligible for Part D drug benefits, including those who are also enrolled in Medicaid. Medicaid would continue (at state option) to provide wrap-around coverage for drug expenses in excess of Medicare benefits for dual enrollees, in accordance with each state's Medicaid plan.</p> <p>Federal Medicaid payments to states would be reduced by a declining percentage each year between 2006 - 2020 to offset the federal costs of providing Medicare drug benefits to individuals who would otherwise have received Medicaid drug benefits so that, by 2021, the Medicare program would assume full responsibility for Medicare drug benefits for these individuals.</p> <p>No provision.</p> <p>If states elect to use prices negotiated by a PDP to provide Medicaid drug benefits, Medicaid rebate provisions would not apply.</p> <p>Prices negotiated for Medicare Part D benefits by a PDP under Part D, by a MA-EFFS Rx plan under Parts C, or by a qualified employer plan would not apply to Medicaid "best price" requirements.</p> | <p>enrolled in Part B are eligible for Part D drug benefits, including those who are also enrolled in Medicaid. States could continue to provide coverage for classes of drugs not covered under Part D (and receive federal matching payments).</p> <p>The federal government would assume 25% of the costs of providing Part D drugs to dual eligibles, phased in over a 10-year period.</p> <p>The Medicaid Qualified Individual (QI) program is extended through September 2004.</p> <p>Prices negotiated for the Medicare Prescription Drug Discount Card program or for Medicare Part D benefits by a PDP under Part D, by a MA-PD plan under Part C, or by a qualified employer plan or SPAP would not apply to Medicaid "best price" requirements.</p> |

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| Treatment of Retiree Health Drug Coverage | Qualified retiree plans with drug coverage at least actuarially equivalent to Part D coverage would be eligible for same government subsidy per Medicare enrollee, based on national average premium (risk and geographically adjusted) for standard coverage. Also eligible for reinsurance of 80% of costs in excess of stop-loss threshold (but employer-covered costs do not count towards stop-loss). | Qualified retiree plans with drug coverage at least actuarially equivalent to standard Part D coverage receive subsidies of 28% of costs for coverage above deductible and up to \$5,000 in 2006 in spending per Medicare enrollee (indexed thereafter). | Qualified retiree plans with drug coverage at least actuarially equivalent to standard Part D coverage receive subsidies of 28% of costs for coverage above \$250 and up to \$5,000 in 2006 in spending per Medicare enrollee (indexed thereafter in same manner as Rx deductible and stop-loss threshold). Payments would not be taxable as income to employers and would be fully deductible. |
| Medicare Supplemental Insurance | No new Medigap policies providing drug coverage could be sold, issued, or renewed after January 1, 2006, to an individual enrolled in Part D. Medigap policies A through G must be guaranteed issued without preexisting condition exclusions to those terminating enrollment in Medigap plans with drug coverage (including nonstandard policies) and enrolling in Part D, if application is made during the Part D open-enrollment period. Medigap issuers must provide written notice during the 60 days before the initial Part D open-enrollment period to each policyholder with drug coverage of the ability to switch to a non-drug policy and that they are ineligible for Part D coverage as long as they retain a Medigap policy with drug coverage. | Beginning January 1, 2006, Medigap policies with drug coverage could no longer be sold except as replacements for policies with drug coverage. Beneficiaries with Medigap drug policies who enroll in Part D would be guaranteed issued a non-drug Medigap policy at the time of enrollment. NAIC would define 2 new Medigap packages that would cover some drug cost-sharing and partial coverage of beneficiary costs for other Medicare benefits. Medigap plans (other than the 2 new plans) would be prohibited from covering the deductible or more than 50% of the cost-sharing in an EFFS plan. | No Medigap policies providing drug coverage may be sold, issued, or renewed after January 1, 2006, except renewals for non-Part D enrollees would be allowed. Part D enrollees who had Medigap policies covering drugs may continue in the policy, modified to remove the drug benefits with an appropriate adjustment in premium; or may enroll in a Medigap policy A, B, C, or F on a guaranteed issue basis (without preexisting condition exclusions), offered by the same issuer, if they apply during Part D open enrollment period. Medigap issuers must provide written notice during 60 days before initial Part D open-enrollment period to each policyholder with drug coverage of their ability to continue in their current plan, as modified to remove drug coverage, or switch to a substitute guaranteed issue policy without drug coverage. The notice must also say whether the policy provides creditable coverage, and if it does not, notify them of the late enrollment penalty for enrolling in Part D outside the enrollment period. NAIC would revise benefit packages to reflect changes in law, and define two new Medigap packages. |

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| | | | The first package would cover 50% of cost-sharing, except 100% for preventive benefits; no coverage of the Part B deductible; coverage of long-term hospital stays; and provide an annual out-of-pocket limit on cost-sharing of \$4,000 in 2006 (indexed annually for inflation). The second package would be similar except it would cover 75% of cost-sharing and have a \$2,000 annual out-of-pocket limit. States may not require insurers to participate as sponsors of Part D plans as a condition for issuing Medigap policies. |
| State Pharmacy Assistance Programs | Allows qualified state pharmaceutical assistance programs in operation as of the date of enactment to receive Medicare drug subsidies (in a manner similar to qualified retiree plans except that all plan payments apply towards stop-loss threshold and enrollees would qualify for subsidies for the low-income). | A State Pharmaceutical Assistance Transition Commission would be established as of the beginning of the third month after enactment to develop a proposal for addressing the unique transitional issues facing state pharmaceutical assistance programs and their participants due to the implementation of Medicare Part D. | State Pharmacy Assistance Programs (SPAPs) may, at state option, provide supplemental drug coverage to Part D enrollees by purchasing extra benefits from a Part D drug plan or providing a supplemental benefit program. SPAP payments on behalf of enrollees would count toward the Part D stop-loss threshold. Appropriates \$62.5 million for each of FY2005 and 2006 to provide federal payments to SPAPs for enrollee education and counseling to facilitate awareness, selection and enrollment in Part D plans. Establishes a State Pharmaceutical Assistance Transition Commission three months after enactment to develop a proposal for addressing the unique transitional issues facing SPAPs and their participants due to implementation of Medicare Part D. Must submit recommendations to Congress and the President by January 1, 2005. |
| Interim Drug Program | Establishes a Medicare Prescription Drug Discount Card Endorsement Program to operate in 2004-2005. Card programs would have to meet specific requirements | Establishes a Medicare Prescription Drug Discount Card Endorsement and Assistance Program to operate within 90 days of enactment through 2005. Card | Establishes a Medicare Prescription Drug Discount Card and Transitional Assistance Program to be implemented within six months of enactment. Card programs |

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| | and charge no more than \$25 in annual enrollment fees. Low-income enrollees (QMB, SLMB, QI) would receive \$600 per year, with balances carried forward on their cards from one year to the next. Government also pays enrollment fee for low-income. Discount card sponsors must provide enrollees with access to negotiated prices, defined to include all discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations. Card sponsors with contracts to administer the low-income subsidies may not charge low-income enrollees more than average wholesale price (AWP) minus 20% for any covered drug. | programs would have to meet specific requirements and charge \$30 in annual enrollment fees (\$20 for sponsor and \$10 retained by government). For discount card program enrollees who do not have other prescription drug coverage (e.g., Medicaid, group health plan, health insurance, etc.), the government would deposit to enrollee card accounts the following amounts: \$800 for enrollees below 135% of poverty, \$500 for enrollees with incomes between 135% and 150% of poverty, and \$100 for enrollees with incomes above 150% of poverty. Balances in the accounts could be carried forward from one year to the next, and amounts could be contributed by employers and other individuals. Card sponsors would have to disclose to the Secretary the extent to which discounts or rebates or other remuneration or price concessions made available to it by manufacturers are passed through to enrollees through pharmacies and other dispensers or otherwise. | would have to meet specific requirements and could charge up to a \$30 annual enrollment fee. Beneficiaries would have a choice of at least 2 card programs (offered by two different sponsors) but can enroll in only one program at a time. Permits Secretary to limit (but not below two) number of sponsors awarded contracts in a state. For discount card program enrollees with incomes <135% of poverty who do not have Medicaid or drug coverage, the government would pay the enrollment fee and deposit \$600 to enrollee card accounts to be used for drug expenses. Subsidized enrollees with incomes <135% of poverty would still be required to pay 10% coinsurance on each prescription; or 5% in cases of those <100% of poverty. Card sponsors would have to pass on to card enrollees negotiated prices on covered drugs and disclose to Secretary extent to which negotiated price concessions are passed through to enrollees. Discount card drug prices would not apply to Medicaid “best price” requirements. |
| Financing of Drug Benefit | General federal revenues. | General federal revenues. | General federal revenues. |
| Medicare Private Plan Reforms Not Related to Drug Coverage | Renames Part C, Medicare+Choice, as Medicare Advantage (MA) and reforms plan payment method. Increases payments to MA plans in 2005, and establishes new payment method beginning in 2006(see below). Adds new MA PPO option. All MA plans must offer coverage of Part A and Part B items and services, a unified deductible for those services, and an out-of-pocket | Renames Part C, Medicare+Choice, as Medicare Advantage (MA) and reforms plan payment method. Increases payments to MA plans beginning in 2004, establishes new payment method beginning in 2006 Establishes Part E with new regional Enhanced Fee-for-Service (EFTS) plans. Establishes FEHBP-style competitive government contribution system in 2010 that includes traditional | Renames Part C, Medicare+Choice, as Medicare Advantage (MA) and reforms plan payment method. Increases payments to MA plans beginning in 2004, establishes new payment method beginning in 2006. Establishes a 6-year demonstration of comparative cost adjustment (CCA) program beginning in 2010 that includes traditional Medicare. |

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| | limit. Plans must also offer standard Part D drug coverage. | Medicare. | |
| Regional Plans | Establishes new regional PPO plans (and removes option for county-based PPO plans) offering enhanced benefits and covering large, defined regions, limited to 3 lowest-cost, credible PPO plans per region. PPO plans must serve an entire region or the entire U.S. At least 10 regions would be defined by the Administrator, each of which includes at least one state, and which cannot divide states. PPO plans paid in same manner as other MA plans, except have shared risk arrangements in first years. Generally, PPO plans must comply with standards applicable to MA coordinated care plans. | Establishes new regional Enhanced Fee-for-Service (EFFS) plans (but does not remove PPO or private fee-for-service options under Medicare Advantage) offering enhanced benefits and covering regions defined by the Administrator, with no more than 3 plans per region. Plans could be fee-for-service or PPOs. EFFS plans must serve an entire region (one of at least 10 defined by the Administrator after a survey of insurance markets). Generally, EFFS plans must comply with standards for MA private-fee-for-service plans. | Establishes regional PPO option beginning in 2006 (“MA Regional Plans”). These plans must serve one or more MA regions (the Secretary will establish between 10 and 50). An organization could offer a plan(s) in all regions. They would have to be licensed in at least one state in which they operate and have applications pending for licensure in other applicable states. No limit on number of plans per region. MA regional plans must offer a single deductible for Part A and B benefits, catastrophic out-of-pocket limits for in-network Part A and B benefits and catastrophic limits for all Part A and B out-of-pocket expenditures. Establishes a Stabilization Fund of \$10 billion for 2007 through 2013 (plus 50% of any savings generated by plans costing less than the benchmark) to provide enhanced payments to MA regional plans to encourage plan entry and retention. Provides for risk-sharing with government in 2006 and 2007 through risk corridors. Plans paid on basis of plan bids in relation to a benchmark (a blend of MA area benchmarks and MA regional plan bids within a region) in same manner as all MA plans (see below). |
| Interim Plan Payments 2004-2005 | Current law methodology except that the minimum increase would be 3% in 2005 instead of 2% (the amount of extra payment would not be carried forward for determining future rates). | In 2004, the capitation rate for each area would be the greater of current law rates or the adjusted average per capita cost (AAPCC) with direct medical education amounts removed and VA/DOD costs included. Budget neutrality would not apply to blend rates in 2004. Beginning in | In 2004 and 2005, the capitation rate for each area would be the greater of current law rates or the adjusted average per capita cost (AAPCC) with direct medical education amounts removed and VA/DOD costs included. Budget neutrality would not apply to blend rates in 2004. |

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| | | 2004, the minimum percentage increase would be equal to the national per capita MA growth rate (excluding any adjustments made before 2004 for projection errors). | Beginning in 2004, the minimum percentage increase would be the greater of a two percent increase or the national per capita MA growth rate (excluding any adjustments made before 2004 for projection errors). |
| VA/DOD Utilization by Medicare Beneficiaries | VA/DOD costs for care provided to Medicare beneficiaries incorporated into calculation of capitation rates and local FFS rates for determination of the benchmarks, effective in 2006. | VA/DOD costs for care provided to Medicare beneficiaries would be incorporated into the calculation of the capitation rates and the AAPCC in each area beginning in 2004. | VA/DOD costs for care provided to Medicare beneficiaries would be incorporated into the calculation of the capitation rates and the AAPCC in each area beginning in 2004. |
| Risk Adjustment | 100% of payments to plans would be risk-adjusted beginning in 2006. | No change is made in implementation of risk adjustment (current law provides for a phase-in with 100% of rates to be subject to risk adjustment in 2007). | No change is made in implementation of risk adjustment (current law provides for a phase-in with 100% of rates to be subject to risk adjustment in 2007). |
| Plan Payments 2006 Forward | MA plans (including new regional PPOs) would submit bids for provision of Part A and Part B benefits (Part D drug benefits would be bid and paid separately). Plan bids would be compared to a benchmark calculated for the service area. Plans would be paid the benchmark amount by the government. Plans with bids above the benchmark would collect the difference directly from enrollees through premiums. Plans with bids below the benchmark must provide enrollees with 100% of the value of the difference between the bid and the benchmark through reduced Part B premium; lower cost-sharing; lower unified deductible and out-of-pocket limit; additional benefits and/or amounts placed in a stabilization fund to offset undue future fluctuations in extra benefits. | MA plans and EFFS plans would submit bids for provision of Part A and Part B benefits (Part D drug benefits would be bid and paid separately). Plan bids would be compared to a benchmark calculated for the service area. Plans with bids above the benchmark would be paid the benchmark and collect any additional amounts directly from enrollees through premiums. Plans with bids below the benchmark must provide enrollees with 75% of the value of the difference between the bid and the benchmark through reduction in premium for Part D or for extra benefits; cash; or other means approved by Administrator. The Administrator must provide a mechanism to consolidate enrollee premiums for Parts C and D. Plans must allow, at enrollee option, for premiums to be paid through deduction from Social Security checks, through an electronic funds transfer method, or otherwise. | Beginning in 2006, a benchmark for providing Part A and B benefits will be computed for each region (see above) and for each local MA plan service area. Each MA plan's bid would be compared to the applicable benchmark. Plans with bids above the benchmark would be paid the benchmark and collect any additional amounts directly from enrollees through premiums. Plans with bids below the benchmark must provide enrollees with 75% of the value of the difference between the bid and the benchmark through reduction in premium for Part D or for extra benefits; cash; or other means approved by the Secretary. The Secretary must provide a mechanism to consolidate enrollee premiums for Parts C and D. Plans must allow, at enrollee option, for premiums to be paid through deduction from Social Security checks, through an electronic funds transfer method, or otherwise. |
| Benchmark – | The benchmark for each area or region | The benchmarks for MA plans and EFFS | The benchmarks for MA plans for Part A |

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| MA Plans | would be the greater of the area capitation rate(s) or local fee-for-service costs. Area (i.e., county) capitation rates would continue to be calculated each year as the greater of the blend, the floor, or the 2% minimum increase. The local fee-for-service rate would equal benefit and claims processing costs for enrollees in original Medicare in the area minus graduate medical education amounts. Regional rates would be weighted averages of rates for areas within the region. Bids and benchmarks would be adjusted for number and health status mix of enrollees in each area. | plans would be the weighted average of the annual MA capitation rates for counties within each plan's service area (for EFFS plans, the service area is the region). Bids and benchmarks would be adjusted for demographics, risk, and geography. | and Part B benefits would be the weighted average of the annual MA capitation rates for counties within each plan's service area (for MA regional plans, the service area is the region). Bids and benchmarks would be adjusted for demographics and health status risk. |
| “Premium Support” System | No provision. | Beginning in 2010, a new FEHBP-style competition program would be established in which traditional fee-for-service (FFS) Medicare would compete with MA and EFFS plans. Competitive areas would be those where there are at least two MA or EFFS plans with penetration of the lesser of 20% or the national MA+EFFS penetration rate. In competitive areas, a benchmark would be computed as the average of the adjusted average per capita cost (AAPCC) of FFS and the MA/EFFS plan bids, weighted by enrollment (the effects of the MA/EFFS plan bids would be phased-in over a 5-year period). Premiums for all beneficiaries in the area would be determined by comparing the plan bids (or, for FFS, the AAPCC without DME and with VA/DOD costs) to the benchmark. To the extent the AAPCC was more or less than the benchmark, beneficiaries in FFS Medicare would have an adjustment to their Part B premium (pay more equal to the difference if the | Beginning in 2010, establishes a "Comparative Cost Adjustment Program," a demonstration to test competition between private plans and traditional Medicare that would be implemented for six years. No more than six metropolitan area demonstration sites would be selected, each having at least two private local plan options that together enroll at least 25% of beneficiaries. Areas with different levels of private plan competition would be selected. In the demonstration areas, the government contribution towards enrollment in traditional FFS Medicare or a private MA plan would be derived from a weighted average of FFS and local MA plan bids. Enrollees in plans below the average would receive premium reductions equal to 75% of the difference between the plan bid and the benchmark; those in plans costing more than the benchmark would pay the difference through an increase in their Part B premium. The impact on Part |

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| | | AAPCC is higher than the benchmark; have the Part B premium reduced by 75% of the difference if the AAPCC is lower than the benchmark). The effect on Part B premiums would phase-in over 5 years to equal the full amount in 2015 and after. Enrollees in MA/FFS plans would realize the difference between their plan's bid and the benchmark through the premium (or rebate) associated with their plan. | B premiums would be phased-in and in no case could be greater than 5% per year; premiums for low-income beneficiaries would not be affected. The demonstration could not be extended or expanded without Congressional action. |
| New Part B preventive benefits | Initial preventive examination: No provision. Cardiovascular disease screening: Medicare coverage of cardiovascular screening tests would be authorized. Diabetes screening: No provision. | Initial preventive examination: Would authorize coverage of an Initial preventive physical examination. Cardiovascular disease screening: Medicare coverage of cholesterol and blood lipid screening would be authorized. Diabetes screening: Diabetes screening tests and services would be included as a covered medical service. | Authorizes Medicare coverage of an initial preventive physical examination, subject to deductible and beneficiary cost-sharing. A covered initial preventive physical examination is one performed no later than six months after the individual's initial coverage date under Part B. Applies to services furnished on or after January 1, 2005, but only for those individuals whose coverage begins on or after such date. Cardiovascular disease screening: Provides for Medicare coverage of cardiovascular disease screening blood tests, effective beginning January 1, 2005. Diabetes screening: Provides for Medicare coverage of diabetes screening for at-risk individuals, effective beginning January 1, 2005. |
| Part B deductible | The Medicare Part B deductible would be set at \$100 through 2005 and then increased to \$125 in 2006. Effective January 1 of subsequent years, the deductible would be increased annually by the percentage change in the CPI-U for the previous year ending in June. | Beginning 2004, the Medicare Part B deductible would be increased by the same percentage as the Part B premium increase. The provision would be effective upon enactment. | Increases the annual Part B deductible from \$100 to \$110 for 2005 and then increases it by the same percentage as the Part B premium increase. Estimated to be \$115 in 2006 and increase to \$166 by 2013. |
| Part B premium | No provision. | No provision. | Provides for income-relating the Part B premium beginning in 2007 for higher- |

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| | | | income beneficiaries. These beneficiaries will see a reduction in the government subsidy of their Part B premium from the 75% currently provided. The reduction is phased-in (in equal increments) over five years. The schedule for the changes in the premium subsidy is: \$80,000 -\$100,000: 65% \$100,000-\$150,000: 50% \$150,000-\$200,000: 35% Above \$200,000: 20%. Income thresholds reflect income for 2007 and then are indexed to increase annually by the Consumer Price Index (CPI). Thresholds for married couples are twice the amounts shown. An estimated 3% of Part B enrollees will be affected in 2007 increasing to 6% in 2013. |
| Administration | Creates new agency within the Department of Health and Human Services called the Center for Medicare Choices. | Creates new agency within the Department of Health and Human Services called the Medicare Benefits Administration. | No new agency is established. Authorizes a center within CMS to coordinate administration of Parts C and D. Requires an actuary dedicated to Parts C and D. |
| CBO 10-Year Estimate of Changes in Direct Spending | \$421 billion net change in direct spending*: \$422 billion for Medicare Rx benefit; \$10 billion for establishing new agency; \$18 billion for health plan provisions; -\$16 billion for fee-for-service provisions; \$1 billion for regulatory reform provisions; and -\$14 billion for Medicaid and other provisions. *Without including section 133 of the bill. | \$405 billion net change in direct spending: \$415 billion for Medicare Rx benefit; \$0 for establishing new agency; \$8 billion for health plan provisions; -\$21 billion for fee-for-service provisions; \$0 for regulatory reform provisions; and \$3 billion for Medicaid and other provisions. | \$395 billion net change in direct spending*: \$410 billion for Medicare Rx benefit; \$14 billion for Medicare Advantage health plan provisions; -\$22 billion for fee-for-service provisions; -\$13 billion from income-related Part B premium; -\$1 billion for regulatory reform; \$6 billion for Medicaid and other provisions; -\$1 billion drug patent changes * All estimates rounded to nearest billion. |

ⁱ QMB, SLMB, and QI refer to categories of Medicare beneficiaries who are not sufficiently poor to meet Medicaid's income and resource eligibility (i.e. "asset test") standards for full Medicaid benefits but do qualify for some degree of Medicaid assistance with Medicare cost-sharing. The asset test varies from state to state but is generally \$4,000 per individual/\$6,000 per couple, excluding certain items such as a home. Specifically:

QMBs: Qualified Medicare Beneficiaries. A Medicare beneficiary with an income below 100% of the federal poverty level and with limited assets. Medicaid pays the Medicare Part B premium and all required Part A and Part B cost-sharing under Medicare.

SLMBs: Specified Low-Income Medicare Beneficiaries. A Medicare beneficiary with an income between 100% and 120% of the federal poverty level and with limited assets. Medicaid pays the Medicare Part B monthly premium for these individuals.

QIs: Qualified Individuals. A Medicare beneficiary with an income between 120% and 135% of the federal poverty level and with limited assets. Medicaid pays the Medicare Part B monthly premium for these individuals. States receive capped allotments for these individuals, so participation may be limited by available funds.



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