EXECUTIVE COMMITTEE MEETING ON AN ORIGINAL BILL ENTITLED, "THE PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003"

THURSDAY, JUNE 12, 2003

U.S. Senate,

Committee on Finance,

Washington, DC.

The meeting was convened, pursuant to notice, at 9:08 a.m., in room SH-216, Hart Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Hatch, Nickles, Lott, Snowe, Kyl, Thomas, Santorum, Frist, Smith, Bunning, Baucus, Rockefeller, Daschle, Breaux, Conrad, Graham, Jeffords, Bingaman, and Lincoln.

Also present: Kolan Davis, Republican Staff Director and Chief Counsel; Jeffrey Forbes, Democratic Staff Director; and Carla Martin, Chief Clerk.

Also present: Dr. Elizabeth Fowler, Chief Health Entitlements Counsel; Linda Fishman, Health Policy Director; Mark Hayes, Colin Roskey and Leah Kegler, Health Policy Advisors; John Blum and Kate Kirchgraber, Professional Staff Members; Thomas Scully, Director, Center for Medicare and Medicaid Services; Douglas Holtz-Eakin, Director, Congressional Budget Office; and Steven

Mr. Lieberman, Assistant Director, Health and Human Resources, Congressional Budget Office.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA (CHAIRMAN, COMMITTEE ON FINANCE)

The Chairman. Good morning, everybody. Thank you for being here. It could be a long day, or it could be a short day. Only time tells when you go through this process that we are involved in.

I very much want to open up by saying that we are here in a bipartisan way, and I am going to emphasize that several times. But, most importantly, for this to be bipartisan it would be because of the working relationship that we have between Senator Baucus and me, not just on this issue or not just because of us, but there is kind of a tradition within this committee of bipartisanship.

It is not always that way, but it is that way most of the time. It is not that way just because we want it to be that way. Not a whole lot gets done in the U.S. Senate if we do not approach it in a bipartisan way.

So, before I thank anybody else, I thank Senator Baucus for working so closely with me. Thank you.

Senator Baucus. Thank you very much.

The Chairman. This will be one of the most memorable days in the Senate. We are considering the biggest improvement to Medicare in the program's history.

We have legislation before us to improve the lives of 40 million older Americans now, and more so in the future.

It is amazing that this is the first-ever Finance Committee mark-up of a bill adding comprehensive prescription drug coverage to Medicare.

We have been discussing it for four years, now, and maybe some members of Congress, much longer than that. So what you will see about this issue, is that you cannot say we have not discussed it enough and that it is not ripe for action.

We are here today because of trailblazers like Senator Frist and Senator Breaux who had a bipartisan Commission on Improving Medicare before most people were talking about Medicare and prescription drugs in the same breath.

We are here because of Senator Baucus, as I have already indicated, but also because of Senators like Senator Hatch, Senator Snowe, and Senator Jeffords. We have worked together on what we jokingly, but very seriously, called the tripartisan team for almost two years now. I believe that, without these efforts, we would not have achieved success today.

In other words, laying the foundation of various people working together, maybe not for exactly the product in the past that we have come up with today, but

a lot of that foundation work very necessary for what I hope will be the success of this day.

So, obviously, we thank those people once again, Senators Breaux, Baucus, Jeffords, Snowe, and Hatch, and people like Senator Frist and Senator Breaux for times before that.

In this closely divided Senate, partisanship is a dead end. I thank everyone for putting their commitment to this shared goal, first.

I want to thank the rest of my Republican colleagues for their support during these two years of developing background and foundational work to get to where we are. They know we have to compromise to get results. I thank them for their encouragement and constructive help along the way.

Last, but not least, I think that we need to thank the President, whose leadership gives us the momentum to get things done now. I remember a meeting early in December with the President at the White House in which he said two things that I think are very meaningful that he demonstrated yesterday, and he has demonstrated in his budget.

Those two things he said at that time, is I am willing to expend political capital to accomplish this goal and I am willing to put a lot of money behind that

goal. The President has delivered.

Now, on the substance of today's legislation, Medicare's treatment of drugs is old-fashioned. It does not reflect the way doctors treat their patients or the way that patients want to be treated.

I have been a farmer all my life. The way I farmed 30 years ago was all right, because we did not have all of the new biotechnology and modern equipment of today, global positioning, and all of that.

But I have taken advantage of a lot of those advancements over the years. It makes sense that farming reflects the latest technology. So be it with Medicare.

We cannot leave Medicare in the last century when medicine is light years ahead. The fact is, we do not have to. We have a bipartisan agreement in this committee on legislation that will bring Medicare well into the 21st century.

That means, of course, on the improvement and strengthening of Medicare, adding a prescription drug benefit. It means harnessing the purchasing power of 40 million people to bring down the costs of drugs. It means getting private companies who want this business to work for it. It means giving older Americans more health care choices.

If they like what they have now, without a doubt,

they can keep it. If they would like a new option, they can have that. If they do not like the new option, they can switch back to what they had before. We are talking about giving seniors the right to choose. That is the way it happens to work for federal employees. That is the way it should work for people in Medicare.

We are not experimenting blindly. We are letting seniors follow well-tested models. My 65-year-old neighbor in New Hartford, Iowa should have the same kind of benefits as the federal postmaster there.

The federal postmaster has it. If there is any doubt if it can be delivered in rural America, if it can be delivered to that rural postmaster it can be delivered to the seniors.

The drug coverage ideas that you see reflected in this bipartisan mark have been around since the House passed it first in the year 2000. My colleagues and I have been working to improve that model ever since.

Whenever real improvements were presented, we took them, whether the source was Democrat or Republican. Today's legislation brings Medicare into the 21st century by making the program more competitive, which will keep costs down. That is far better than price controls which stifle innovation.

Today's legislation also extends Medicare's historic

discrimination against States that do more with less. Now Medicare's complex funding formula penalizes States such as my State of Iowa for practicing high-quality, cost-effective medicine.

The penalty is an unfair reimbursement rate. Health care providers and hospitals in 30 rural States get less money back from Medicare for the same procedures that would be performed in Florida or New York.

This creates a disincentive for physicians to practice medicine in these rural States. It pinches an already razor-thin operating margin for our vulnerable hospitals. It hurts the quality of care in rural communities.

Today's proposal will fix those inequities. It ends the unfairness of paying the same Medicare payroll tax everybody else does, but getting less in return.

Medicare is critically important. But you know, there is a whole lot more at stake. If we act today, we will go a long way towards answering some serious concerns that the American people have. We will demonstrate that the U.S. Senate can work after all.

We will show that the Senate Finance Committee is still a place where we come together across party lines solving our problems. Most of all, we will tell the American people that we do listen to them.

To me, this mark-up is a matter of accountability. Both parties have promised for years to add prescription drugs to Medicare. At least in Iowa, when we make a promise, we intend to deliver.

So we are here today as members of the Senate Finance Committee to deliver. People in Iowa do not want to hear why we could not agree on details. They want to hear how we got it done, and that we did get it done.

The conventional wisdom was that a Senate split almost right down the middle could not be expected to produce anything, particularly in this area of Medicare strengthening and improvement in prescription drugs.

Well, we did what we farmers do every spring. Even though we did not know if we would get the results in the fall, we kept at farming every day, day after day, with a little faith and you produce a production. There is more ground yet to be plowed, but we are further along than most people believed possible. So, now let us just finish the job.

Senator Baucus?

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator Baucus. Thank you very much, Mr. Chairman.

This is a big day. We are about to pass landmark health care legislation that will have more significance than a lot of other legislation recently passed. I am very proud of the joint efforts of everybody on the committee, including some of those off the committee, who have helped make this happen. There has been a lot of effort over a lot of years.

Often it takes, frankly, a couple, three years' efforts to get to the point where we reach an agreement on what the components of the bill should be, and we are here at that point.

As I look around the table here, I am reminded of members who have worked so hard on health care, Senator Graham, certainly, Senator Breaux, Senator Jeffords, over the years. On the Republican side, certainly Senator Hatch, as well as the Chairman.

I might say that the Majority Leader, Mr. Frist, too, is a large reason why we are here today. This has been a major goal of his, to get this passed this year. Add to that the administration. It is also a major goal of the administration. I know that it is a major goal for all

of us on both sides of the aisle because seniors so desperately need the help.

I pay particular compliments to you, Mr. Chairman, for your leadership in bringing people together. You have this amazing knack just to listen to people on both sides and to figure out what is best. Were it not for your leadership, I doubt we would be here today.

The great Israeli statesman Aba Eben used to say about his adversaries, "They never miss an opportunity to miss an opportunity." Well, my plea to members of the committee today is, let that not be said about us.

If we really stop to think about it, we have an opportunity to make available Medicare prescription drugs universally to all seniors. That is no small matter. We have before us the opportunity to ensure that more than a third of Medicare beneficiaries, those with the lowest incomes, would have truly affordable prescription drug coverage with minimal out-of-pocket costs. Again, no small matter.

We have before us the opportunity to ensure that those who have been least able to receive the healing benefits of prescription drugs would now be able to do so. Millions of people will have a better quality of life. Lives will be saved.

We have the opportunity to make it so that the

elderly retired couple in Great Falls, Montana with an income of $16,000 a year would be able to buy their drugs without ever having to pay more than 10 percent of the cost of their drugs.

We have before us the opportunity to create a strong government fall-back. Seniors would have access to at least two private plans for a prescription drug benefit or the government would provide a standard fall-back plan. If there is not true competition, then traditional Medicare provides a fall-back.

We have before us the opportunity to create a $400 billion expansion of a major entitlement program. Yes, we could have done more with more money, but this is an historic opportunity to make a fundamental change for the better for millions of Americans.

We have before us the opportunity to do something that the overwhelming majority of industrialized nations have already done. We have before us the opportunity to end the painful choice that millions of our seniors are now faced to make, between filling their prescriptions and buying food. Seniors should not have to choose among the necessities to maintain their health.

We can do something about that today. Let us, at last, make the benefits of prescription drugs available to those who have been least able to afford them. Let us

choose to improve, and yes, oftentimes to save, these lives. Let us not miss this opportunity. Thank you.

The Chairman. Thank you, Senator Baucus.

Normally, I would call on Senator Frist and Senator Daschle, first. But I wondered if there would be deference to Senator Hatch because of chairing a very important Senate Judiciary Committee.

Senator Daschle. That is fine.

The Chairman. So, Senator Hatch.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A. U.S. SENATOR FROM UTAH

Senator Hatch. Well, thank you, Mr. Chairman, for letting me proceed now, and also to our two Leaders. I am very grateful to you because I have to chair the Judiciary Committee mark-up. I hope to return shortly from that.

Let me abbreviate my remarks and ask permission to submit the rest of my statement for the record.

But, first, I want to extend my congratulations to both you and Senator Baucus, our two Leaders as well, on a job well done. This is a landmark occasion for everyone, especially Medicare beneficiaries across the country.

Seniors have been waiting for the last 38 years for a comprehensive and permanent Medicare prescription drug benefit. We are here today to tell America's seniors they will not have to wait much longer. Help is on the way.

Last year, we worked hard to pass a drug benefit for our seniors. Those of us who had the pleasure of working on the tripartisan group spent a year and a half writing our bill. It was truly a labor of love and we are proud of that effort. But for partisan politics, I believe, it

would have passed the Senate.

That being said, Mr. Chairman and Senator Baucus, you have outdone us. This legislation builds on several important foundations that we laid in the tripartisan initiative, and in many ways it is far superior to that bill.

It offers beneficiaries the benefit through the private sector with reasonable and fair cost sharing. Beneficiaries will have the ability to obtain the drugs of their choice without government interference and with better coverage choices.

In contrast to last year's bill, the measure we have before us today provides beneficiaries with several choices: a stand-alone drug benefit, a drug benefit through a PPO, or a drug benefit through an HMO.

There are many other features, but I also wanted to mention the provisions ensuring access to rural areas, which again are an improvement over the bill we worked on last year. This is a must-do for my own home State of Utah.

The bill also improves the Medicare program by providing beneficiaries choice in health care coverage. If seniors wish to remain in traditional Medicare, they may do so. If seniors want to keep their Medicare+Choice plan, they may do so. If seniors want to enter into a

new PPO option which is modeled after private health insurance, they may do so. So, there are choices for everyone.

Finally, the Finance plan also provides more generous coverage for low-income beneficiaries by giving assistance to those who are below 160 percent of the federal poverty level.

One of my primary goals is to provide additional assistance to those who need it most and are struggling to pay for their prescription drugs.

Mr. Chairman, I want to thank you for including my provision which would provide additional incentives to the 19 States, including my home State of Utah, which include those between 74 and 100 percent of poverty in their dual-eligible programs.

Now, I have to say you have also improved the process for consideration of this issue. Under your leadership, Mr. Chairman, we have had a hearing on this bill and we will mark-up this legislation in committee today before we go to the Senate floor.

The legislation is supported by both the Chairman and Ranking Minority Member of the Senate Finance Committee and indeed will be supported by a majority of the Finance Committee members.

So what a difference a year makes! I am very proud

to have worked with all of our colleagues on this committee. Each and every one has contributed in putting this legislation together. We have all had our likes and our dislikes with regard to this, but I want to compliment everybody concerned.

In conclusion, passing this legislation is the right thing to do for our seniors. I am so proud to have played an important role in making this dream a reality for Medicare beneficiaries across the country. I think this is an historic day for the Senate Finance Committee and for the Senate as a whole, and I want to thank all of those who have participated in it.

Thank you, Mr. Chairman.

The Chairman. Thank you.

[The prepared statement of Senator Hatch appears in the appendix.]

The Chairman. I would now call on Senator Frist and Senator Daschle, if they want to make their presentations, because of their busy schedules.

Senator Frist?

OPENING STATEMENT OF HON. BILL FRIST, A U.S. SENATOR FROM TENNESSEE

Senator Frist. Thank you, Mr. Chairman. I want to congratulate you and Senator Baucus for your tremendous contribution in advancing what, to me, is a major priority, to this body is a major priority, and indeed to the American people a major priority.

I want to thank you for the work you have done and the efforts that you have made in so many ways so that we can take this next step in modernizing Medicare, yes, adding benefits, and doing it in a sustainable way, a way that makes sense for now, 5 years from now, 10 years from now, and can be sustained long term. That must be our goal.

The title of this bill is S. 1. It is a bipartisan bill. I want, and am committed to, making the process work. This is really the first step in terms of the debate, amendment, and deliberative process that will play out over the next week, two weeks, and two and a half weeks.

It is S. 1 because the American people deserve it, not just seniors and individuals with disabilities today, but those near-seniors, and indeed those future generations. They simply deserve better health care

security.

Second, I do want to emphasize that this is the next step. This is not the final product. In fact, many will, for the first time, be dissecting the various intricacies of the bill. The bill is complex. This is a bold initiative.

It is a big initiative and it is going to take the very best of our deliberative process, the very best of our right opportunities to amend, to make absolutely sure that we have the very best product that the U.S. Senate, in a bipartisan way, can generate. That is a big challenge.

For those of us who had the opportunity to serve several years ago on the bipartisan Commission on the Future of Medicare and for those of on this committee who have been addressing the modernization of Medicare for years now, I want to say thank you, because it is upon your shoulders and the work over the last four years that this bill has been generated.

I think people are surprised at the fact that there is, at least coming out of the chute, a real bipartisan commitment of what is in the bill. Again, it is going to be modified, I am sure, as we go forward. But that there is a general consensus being reached that now is the time. It is the time we have all waited for.

The reason that is the case, is first of all the system is working, but second that we, in truth, are looking at bills and parts of bills and issues that we have addressed again and again in the past, that we have debated, that we have held hearings on, over 30 hearings in the past on Medicare.

All of that brings us to this--and we say this for so many bills--truly historic opportunity to do something good for seniors, but really every American.

We do have a lot of work to do. We need to make sure the deliberative process works in the very best sense of the way in terms of debate, in terms of discussions, and in terms of amendments in this committee.

I do plan, if we are successful over the course of today, which I believe that we will be, to bring this bill to the floor of the U.S. Senate next Monday.

I do also want to commend the President of the United States and his bold leadership. The framework for reform that the President set forth has been an important catalyst for action.

The product that we generate will be the product of this committee, and that is crystal clear to people who have seen what is in this initial mark. But I do want to thank the President for making a really indelible impact as a catalyst for this legislative effort.

For nearly four decades, Medicare has provided peace of mind and health security for millions of seniors and individuals with disabilities. I have been a beneficiary in the sense that I have had the opportunity in the field of medicine, for the 20 years that I spent in medicine, to every day be able to treat and work with Medicare patients.

It is going to take real leadership because this program, as good as it has been and as cherished as it is, is not what we would like for it to be if we really have a goal of health care security.

Since 1965, we have had huge advances in terms of science, in terms of medicine, in my own field of heart surgery, lung surgery. Transplants were not even done back when we started Medicare.

But also there have been huge advances in health delivery systems. And we do not have all the answers yet, but we need to have a Medicare framework and structure that at least is up to date and is modern. Medicare right now, as delivered, is not.

For example, Medicare covers only about half of the typical seniors' health care costs. Most seniors do not realize that. Medicare lacks good preventive coverage. It does not cover things like cholesterol screening, which we know is important to heart disease.

It covers very little of wellness care, very little of chronic disease management. It does not even cover the cost of an annual physical exam. Most seniors, most Americans, do not realize that.

It does not protect against large, catastrophic, out-of-pocket costs, expenses, the so-called catastrophic health costs. There is no upper limit today in Medicare. No matter who you are or how poor you are, in Medicare today there is no limit in those out-of-pocket expenditures. Most seniors just do not realize that. Most Americans do not realize that.

What most Americans do realize, is it does not cover outpatient prescription drugs. Clearly, we need to address that.

I mention it because it is important that we lead, as this body, because most Americans do not realize the inadequacies, the antiquated aspects of Medicare, and we have an obligation, I believe, to lead to both educate people broadly, but also change the system to bring it up to date.

We all know the demographics, the unprecedented shift in demographics, this tidal wave that is moving through with the doubling of the number of seniors and fewer workers paying into the system.

We have to keep coming back to that because that puts

a very predictable variable coming forward that factors directly into, whatever we do today, whatever promises we make, is it sustainable long term.

That demographic shift has to be in the back of every amendment we vote on, every decision that we make, because whatever we do today cannot be over-promising, whether it is in terms of resources or benefits today without a recognition that we are going to have this doubling of the number of seniors with fewer people paying into the program.

In closing, now is the time to act. I think we must absolutely act responsibly. What we do today will affect every single American. What we do today, and over the course of the next two and a half weeks, will affect every single American.

I do want to thank our leaders, the Chairman and the Ranking Member, for their tremendous leadership and look forward to participating in the debate and discussion that will provide a stable structure, a sustainable structure that will provide health care security for generations to come.

Thank you, Mr. Chairman.

The Chairman. Thank you, Senator Frist.

Senator Daschle?

OPENING STATEMENT OF HON. TOM DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator Daschle. Thank you very much, Mr. Chairman.

Let me begin where our distinguished Majority Leader left off. I, too, believe we have to start today. This is an historic moment. I, too, commend our distinguished leaders on the committee for the remarkable bipartisanship that they have demonstrated yet again in bringing us to this point.

We may have more significant differences about the bill substantively, but I hope I can demonstrate the same bipartisanship when it comes to the floor as we consider this legislation beginning next week.

I also want to commend others who have brought us to this point. I just told Senator Breaux that I do not believe we would be here were it not for his extraordinary efforts over the last many years, and I believe that. Senator Snowe and others deserve a great deal of credit for having brought us to this point, and I commend them all.

There are those who have attempted to find metaphors for the current state of Medicare. Some have called it antiquated. Some have suggested that it be thrown out, that we start all over, that we recognize its antiquated

ways and find a new paradigm, a new infrastructure for health delivery for seniors.

I was driving to work this morning and it occurred to me that I believe Medicare is a lot like our Capitol building. It was built originally in 1791. It has been expanded five times up until now. It is now under renovation of real consequence with the construction of the Visitor's Center. Over the years, it has adapted. It has served 240 million people and all of us, 1,875 Senators, extremely well.

But we have not been content to leave it as it was in 1791 or in 1953, the last time it was renovated with major reconstruction and effort. We have renovated it, we have adapted it, we have modernized it. We have brought it into the next century, adding telecommunications and the vast array of changes to accommodate the new needs and demands put upon the building.

Medicare has to be the same. We would not, I hope, ever advocate the destruction of the building, starting over with the Capitol, any more than I think we should with Medicare itself.

We have something that has worked well now for 40 years. We need to renovate it. We need to add to it. We need to reconstruct it, adapt it to current

circumstances. But I hope, as with the Capitol, we will recognize the value of Medicare.

Seniors deserve this benefit. They have waited a long time. They are not asking that we do anything more than we have done for ourselves. They are hoping that we do it right.

Right, to them, means that it stays affordable, that it be reliable, that it be simple, and I believe the overwhelming majority, perhaps as many as 80 to 90 percent of those seniors, would like it to be done through Medicare itself.

So this is our chance to do it right, to respond to that need, to adapt Medicare to a new time. But I think we have to be honest. I think it is very important that we not over-promise with what it is we are doing today.

In fact, 7.2 million senior citizens have prescription drug benefits exceeding $5,000. We have done a calculation on this bill and its application to those who have those drug costs of $5,000.

I think we need to be honest that, according to the calculations that we have been able to make--and I would ask anybody to refute this if it is not accurate--to the best of our ability, we have been able to determine that of that $5,000 a senior citizen will pay in drug costs once this bill is enacted, they will still have to pay

$3,300 of that $5,000 once the bill is enacted.

So I believe that we have a need to be honest. They will pay about $100 for Medicare, $58 for Part B and at least $35 for prescription drugs. That, too, requires our frank and very candid assessment of the value of the benefit.

Some have said, well, we think this ought to be just like FEHB, and I could not agree more. But if we had an FEHB system for seniors, we are told by those who have analyzed costs that this program today, this bill, would cost $800 billion, not $400 billion.

The benefit difference is about $1,000 between members of Congress and senior citizens themselves. That is, we get $1,000 of additional benefit under FEHB than seniors will once this bill passes.

So, again, I hope that we are careful not to over-promise. I hope we are not too hyperbolic with regard to what it is we are doing here. I hope we can be honest.

I know that we cannot address all of our issues in the committee. I am very hopeful that we can offer an amendment that will bring down costs for everybody with the generic legislation that could be offered on the floor. That will improve it.

I am also hopeful that we can add improvements here in this committee with regard to the structure, the

benefits, and providing the kind of opportunities to address the concerns of affordability, reliability, and simplicity that seniors want.

But we are starting here, Mr. Chairman, and I realize that over the years we may have to revisit this on a number of occasions. But I applaud you for giving us the opportunity to start, and I am grateful for the mark-up today.

The Chairman. We appreciate your courtesies.

Senator Baucus and I have agreed that we will now go to the three-minute opening comments of members, according to their entering into the committee meeting. Then we will go through what we call our walk-through of the modification and of the bill. Then at the end of that, he and I will assess how we will handle the rest of the day.

We have also agreed that, if we have votes on the floor of the Senate, that he and I will alternate going so we can keep this meeting going during the votes on the floor so we do not lose any time that way.

Now, I call on this order: Senator Snowe, Senator Breaux, Senator Thomas, Senator Conrad, Senator Bunning, Senator Bingaman, Senator Jeffords, Senator Rockefeller, and Senator Graham.

So, Senator Snowe?

OPENING STATEMENT OF HON. OLYMPIA J. SNOWE, A U.S. SENATOR FROM MAINE

Senator Snowe. Thank you, Mr. Chairman. I want to congratulate you for your fortitude and perseverance and persistence in forging this bipartisan consensus.

I thank you, Senator Baucus, for your unwavering commitment to achieve this agreement as well, and to the Leader for establishing an ambitious timetable, as well as ample floor opportunity to make this process work.

Also, in responding to the President's charge to complete this legislation in July so that we can be assured of enactment, this prescription drugs. More importantly, that seniors can be assured of a prescription drug benefit.

Margaret Thatcher once said, "You may have to fight a battle more than once in order to win it." Well, we have been fighting this battle, but now we can win it. We can win it with this legislation by enacting the most monumental change to the Medicare program since its inception in 1965.

The policies in this legislation before us is consensus-driven. It obviously was not developed in a vacuum. Obviously, this has been a descendent of the tripartisan effort and other efforts. It has been the

result of an evolutionary process. It has been subjected to numerous iterations and ceaseless vetting.

It obviously required a competition of ideas to bring us to this point, recognizing that it is impossible in the 51/49 Senate to enact the most significant enhancement to Medicare in 38 years, the largest domestic investment in nominal terms ever, with a "my way or the highway" approach.

Concessions have to be made, and thankfully they have, Mr. Chairman, on all sides of the equation: the President, Republicans, and Democrats along our respective ideological spectrums, because I think we finally have recognized we can no longer hold seniors' futures hostage to political unwillingness or inability to compromise.

Now, we have obviously recognized that there are some critical issues that we have to embrace in any prescription drug program. Again, derived from the lessons that we have learned through these countless negotiations over the last five years.

One, is the principle of making sure it is universal, that it is affordable, that it is permanent, that it is sustainable, that it is equal, that we target assistance to low-income beneficiaries in this program.

I know that some would prefer a government-run

system, but we also drew upon those lessons learned last year, that CBO estimated that it would cost at least $600 billion, perhaps as high as a trillion dollars, that we would have to sunset the program, that we would statutorily limit the number of drugs seniors could purchase in any therapeutic class to just two.

The bill before us is a consensus. It is permanent. It does not sunset. Government does not limit the number of medications. Now, I know on this side my colleagues wanted to encourage more seniors to move into the privately-delivered systems.

Again, given the various fluctuations and discrepancies between CMS's estimates that 43 percent of seniors would enroll in a private network, to the low estimates by CBO of 2 percent, we obviously had to embrace in this legislation a very cautious approach so that we did not jeopardize the program of the seniors' future.

Seniors should have the option of staying where they are comfortable without sacrificing guaranteed equal prescription drug benefits, at the same time having the option of moving into a private network without undermining the traditional fee-for-service safety net.

Mr. Chairman, I should say that we have the opportunity here today either to use this issue to play

politics or to pass policy. I hope that we will be able to surmount the political and the policy hurdles, to travel the last mile to carry the Medicare program into the 21st century.

Thank you.

The Chairman. Thank you, Senator Snowe.

[The prepared statement of Senator Snowe appears in the appendix.]

Now, Senator Breaux.

OPENING STATEMENT OF HON. JOHN BREAUX, A U.S. SENATOR FROM LOUISIANA

Senator Breaux. Thank you very much, Mr. Chairman.

Let me just say that a whole lot of people have done a whole lot of work over a very long period of time to get us here, and I would like to say my appreciation, thanks, and congratulations to both you and Senator Baucus for putting together a package that is actually going to get a majority of support in this committee and a majority in a bipartisan fashion.

I want to particularly say thanks to all of our staff who have done just incredible work. To Liz Fowler and Linda Fishman, thank you so much, and your team, for doing the work that you all have done. They have been up 24 hours a day, practically, over the last couple of days.

And also to Tom Scully, who is not here. He is out doing some more numbers, I think. We thank him for doing the work that he has done with Doug Holtz-Eakin. Doug, thank you for your team. We do not always agree with the numbers, but you all have really been crunching them in a way that has been very important.

And to my own staff, particularly Sarah Walters, who has a particular interest in us getting this bill done in

a timely fashion because of other duties she has to attend to, like having a baby, I thank them as well.

I think that when we were running the Medicare Commission, people would come up to testify and a lot of people had two different opinions on how we should do this. Some said the government should have to do it all and that the private sector could not do anything.

There was a different group of people that would come before us and say, no, you have got it just exactly opposite. The private sector should do everything and the government should get out of the way and get out of the business.

I think what we have been able to put together is a combination combining the best of what government can do with the best of what the private sector can do. It truly is a vehicle that will get both entities to do the best job they are capable of doing.

Some of the editorials this week have said this bill does far too much, and some of the editorials have said this bill does far too little. I think, in fact, it just about gets it right with the amount of money we had to deal with.

Our Leader is exactly correct, we need more money to make this program a 21st century, first-class Medicare plan. It is not there yet, but it represents a huge and

a major step in the right direction by trying to move away from these old arguments about one group doing it all and the other group not doing anything.

I have tried, in our chart, to summarize, perhaps, for a lot of people out there trying to figure out exactly what we do. I have these little charts to maybe help our colleagues. I tried to take 90 pages of notes and put it on one chart, and it is not easy to do that.

But what we have, is a beneficiary who, beginning in January, will have for the first time a Medicare government prescription discount card, somewhere between 20 and 25 percent, that will be available to all Medicare beneficiaries. That starts right away.

And for low-income beneficiaries, they will have an additional approximately $600 subsidy to help them in addition to the discount card. That starts right away.

It is going to take some time to start the rest of this program, to do it right. I was talking to Senator Conrad. We want to make sure it is put together right. You cannot do that overnight.

Between now and the year 2006, HHS, the Federal Government, will set up the new plan. For all the seniors who like what they have and do not want to change, they can stay right where they are in the box on the left.

They will stay in traditional fee-for-service. They will still have the combined deductibles, A and B. But they will for the first time have a prescription drug plan. It will be government run, but the government will utilize for the first time the private sector to deliver that package.

That package has a standard beneficiary package of drugs of about a $275 deductible, a 50 percent cost sharing, and a premium of approximately $35 a month, which is about what many senior groups said they were willing to pay if they got a pretty good package.

There is a gap. Our Leader has talked about the gap. I wish it was not there. But the gap is between $4,500 and about $5,800, where seniors would have to assume the cost. But after they reach that amount, then the government pays 90 percent of it. I wish we did not have the gap, but we can work on it.

The average senior in the year 2006 is projected to have average prescription drug costs of about $3,155, so most seniors, on average, will be below that gap. They will not experience the gap. Then those that reach the larger amount will have the government pick up 90 percent of their costs. That is for people who stay right where they are.

The new Medicare Advantage is a choice. It is a

choice that people can take if they want to move into the new system. They are not forced to do that. They will have a delivery system which is very much like what we have.

HHS, the Federal Government, will run the program but utilize a private sector delivery system to bring about hospital benefits, drug benefits, and doctor benefits. Their drug plan will be exactly the same as people who stay in traditional fee-for-service.

That is why I think, when we make the point that what we are trying to do is to put the best of what government can do and the best of what the private sector can do, I think we have done that.

We require that every region of the country have at least two plans presented to the seniors in order to participate. If they do not, the government is going to be the fall-back provider. I think that is very important, particularly for rural parts of this country.

So, on balance, I think we have constructed, not the perfect plan, but I think a major improvement, and thank everybody for their tremendous help and involvement.

Thank you.

The Chairman. Thank you, Senator Breaux.

Now, Senator Thomas?

OPENING STATEMENT OF HON. CRAIG THOMAS, A U.S. SENATOR FROM WYOMING

Senator Thomas. Thank you, Mr. Chairman. I will try and be brief. I think most everything has been said, but we all have to say it, of course.

I do believe that we face no greater challenge domestically than to do something with the Medicare program and to provide seniors with access to prescription drugs. I hope we see this as where we want to be in the future.

I know you have to get all tangled up in details, but we really ought to be looking at our vision of where we want to be in 15 or 20 years. I think the Medicare program is outdated and some efforts need to be made to change that. That is what we are doing. We need to improve the quality.

Seniors should be able to choose among different programs. The best option for that, of course, is the Federal Employees Health Benefit Plan, which is what we are seeking to put into place. So, I appreciate the hard work that has gone into it.

I am especially pleased with the rural package that is there so we can get some equity in the country and have that kind of service. Certainly, we have a chance

to move ahead.

I do think that there is relatively little reform here unless we can make this alternative package attractive, and that is where I see us going in the future, and I hope that we can do that. They need to be as competitive as possible. I am delighted, and thank both of you for getting us here. We need to keep moving.

Thank you.

The Chairman. Thank you, Senator Thomas.

Now, Senator Conrad?

OPENING STATEMENT OF HON. KENT CONRAD, A U.S. SENATOR FROM NORTH DAKOTA

Senator Conrad. Thank you, Mr. Chairman. Let me, first, congratulate our Chairman and our Ranking Member for really a remarkable job of bringing us together. This is history-making. It has not been easy. I think all of us know, there have been some very tough sessions that have led us to this point. I think that makes the credit that goes to the two of you even greater.

I think we should also acknowledge the extraordinary work of Senator Breaux over an extended period of time to bring us to this point, and to Senator Frist on the other side for his strong leadership, because without it it would have been more difficult to be here.

I think we should also recognize Senator Rockefeller. If there is anybody that has labored to get a prescription drug benefit, it is Senator Rockefeller, and we thank him for his dedication to the cause.

We should also thank Senator Snowe, who cared deeply about this subject and has been deeply involved, and to Senator Hatch, who was involved in the Commission, and to Senator Graham, who offered a very significant alternative that helped build momentum for this day, and to Senator Jeffords who played a key role in that as

well. All of these people deserve extraordinary credit for our being here today.

The fact is, the pattern and practice of medicine has changed. Senator Moynihan made the point so well when he would hold up the *Merck Manual* that was in effect when Medicare was passed. It was a very slim volume of prescription drugs. Then he would hold up the *Merck Manual* of today and it is a weighty volume.

The fact is, these are changes that require an updated Medicare. We have to have a prescription drug benefit if we are going to have a modern Medicare.

Just one example. Stomach surgery has been reduced two-thirds by prescription drugs, and that same change is reflected in many other parts of medicine as well.

Four out of 10 people do not have drug coverage in this country. In my State, it is even worse. So, this proposal is a major step in the right direction.

At the same time, I do not think we should over-promise or over-sell. The fact is, there are significant shortcomings here. But I think we should start with what is right. This is going to provide coverage for millions of American seniors.

It is especially important for those below 160 percent of poverty and those who face very high prescription drug costs. It does not require seniors to

leave traditional Medicare to get coverage. That is a very important point, and we should tell it.

It also, in the Medicare provisions, makes a real commitment to addressing the rural inequities that currently exist. I want to salute the Chairman and the Ranking Member. Thank you for including the provisions in the H Care bill that Senator Thomas and I have offered. It is going to help level the playing field.

And on chronic care, 5 percent of Medicare beneficiaries use 50 percent of the budget. Five percent use 50 percent. Senator Frist said it well, we need to coordinate that care to get better care and to reduce cost.

This bill has a significant demonstration project, both one authored by the Senator from Arkansas and one authored by me based on Budget Committee hearings we just held two weeks ago.

Finally, on the shortcoming side, very briefly. There is $400 billion to work with here. If we were going to provide the benefit federal employees have, it would cost twice as much, $800 billion.

If we were to provide the coverage that we give to our military members, it would cost $1.2 trillion, three times as much. You cannot do as much with less money. That is a reality.

Finally, on instability. This is the one area, Mr. Chairman and Senator Baucus, that I would hope that we could improve on because it does concern me. We could have seniors be in four different plans in four different years, and we could have them facing different premiums, different co-insurance levels, different requirements with respect to where they get their prescription drugs. I think that would create confusion.

I know this is a difficult area, but I would hope very much, before we are done with this process, we find a way to reduce the instability. I thank the Chair and Ranking Member.

The Chairman. Thank you, Senator Conrad.

Now, it is Senator Bunning's turn. After Senator Bunning, we would go to Senators Bingaman, Jeffords, Rockefeller, Graham, and Lott.

Senator Bunning?

OPENING STATEMENT OF HON. JIM BUNNING, A U.S. SENATOR FROM KENTUCKY

Senator Bunning. Thank you, Mr. Chairman. My congratulations to you and to Senator Baucus for getting us to this point. All I can say is, hallelujah, it is about time!

In 1965 when we began this program, who would have thought that we would be here for the first time changing it dramatically, not only adding a prescription drug benefit, but also adding a total health care package that will be available to each and every senior.

We have talked about creating a Medicare prescription drug benefit for years, not only here in the Senate, but over in the House where I lived in the Ways and Means Committee for eight years. The same inaction was taken there. We would get to a point and we would never get a bill out of the committee.

So, 40 million seniors have been waiting for this. This is a step in the right direction. It is a major step in the right direction. This gets us closer to our goal.

Seniors across the country are tired--believe me, I have heard from them--of politicians promising a prescription drug benefit year after year, only to be let

down year after year.

I am especially pleased that we are providing a very good benefit to our low-income seniors, particularly the QMBs, SLMBs, and the QI-1s. Those are the people that are at 135 percent of poverty or below.

These seniors have an annual income ranging from 73 percent of the federal poverty level to 135 percent of the federal poverty level. It is these people who really need this benefit the most. I am glad we are giving them something substantial in this package.

I think we have a good bipartisan bill before us today that I hope we can move through the committee and through the Senate without too much trouble. Again, my congratulations go to all who have worked, Senator Breaux, Senator Snowe, Senator Frist, Senator Jeffords, and all of those who have had a great interest in this bill to get it forward to the point it is today.

Thank you, Mr. Chairman.

The Chairman. Thank you, Senator Bunning.

Now, Senator Bingaman?

OPENING STATEMENT OF HON. JEFF BINGAMAN, A U.S. SENATOR FROM NEW MEXICO

Senator Bingaman. Well, thank you, Mr. Chairman. I join everyone in congratulating you and Senator Baucus, and all of the others who have just been named several times. I do think there are a lot of people on this committee, and some off this committee, who have worked very hard to get us to this point.

I particularly appreciate the commitment that the Majority Leader has made to getting this passed through the Senate. I think that is very important and look forward to working with him on that.

Let me just mention a couple of particulars in the bill. The provisions dealing with rural health and the providing of care to citizens in rural areas, I think they are very important. I appreciate you having those in here. Those have been developed over a period of years and they are very important in my State.

I have some concerns. Let me just mention two or three categories of concern. One, is the complexity of the bill. I think this bill is incredibly complex. I hope that seniors will not have to hire accountants and attorneys to tell them what their options are once this gets enacted. I hope we can take some steps today in

this mark-up to lessen the complexity.

One aspect of the complexity is the volatility or instability that is built into this structure. I hope we can lessen that. I hope we can ensure folks that companies coming into this program, whether it is to provide drug benefits or to provide more comprehensive care, stay in it a little while and actually stay the course and try to provide those benefits and not come in and out.

On the coverage gap, Mr. Chairman, in your statement you said you wanted to be sure that your 65-year-old neighbor there in Iowa would have the same kind of benefit, I believe you said, that the rural postmaster has.

I do not know exactly what we mean by "kind of benefit," but clearly, under this proposal, your 65-year-old neighbor is not going to have the same benefit.

The Chairman. No, you are right.

Senator Bingaman. I think we need to be clear to all Americans that we are not giving them anything like that federal employees have, what we have here in the Congress.

They will, on average, be paying maybe 30 percent, or will have Medicare pay 30 percent of the costs of prescription drugs, on average, for most seniors, which

is a benefit. I am not suggesting it is not a benefit. I am just wanting to be real clear that it is not the comprehensive kind of a benefit that many of us had been hoping for.

Finally, let me just mention the concern about doing no harm. I am informed that the Congressional Budget Office estimates that about a one-third drop in retiree employer plan drug coverage.

It also estimates that some low-income beneficiaries may find their own State dropping Medicaid drug coverage in order to have it replaced by this, which would be a benefit with a far greater cost share.

I hope we can do something in the course of writing this legislation, if those figures are accurate, if those estimates are accurate and credible, to ensure that we do no harm, that we do not cause employers to back out of the system, that we do not cause States to withdraw coverage under Medicaid as people move into this system. This system will not be as generous and I think we would be doing a disservice to seniors if we allowed that to happen.

But, again, let me just conclude by congratulating you and Senator Baucus on the great progress you made and the bipartisan approach you have taken. I look forward to working with you today to see if we can improve the

bill, and then I look forward to working with all colleagues when we get to the Senate floor.

The Chairman. I think your statement asking for clarification of what I said is very accurate. I would further clarify and say there is one reason I make the point I did about the postmaster in the little town of New Hartford.

Number one, is that some people have doubts if such a program could be administered for seniors, because would it be available in rural America? I say, if we can do it for federal employees, we can do it for senior citizens.

Second, would be to show that, particularly baby boomers, even though we do not have something identical with federal employees, what the new plan patterned after the federal employees would have would be closer to what most baby boomers have at their workplace as opposed to current Medicare not being anywhere close to what people have at the workplace.

Now, if I could introduce Senator Jeffords. Senator Jeffords, I have thanked many times for working hard on this over the last two years. But just in case people do not understand what "tripartisan" means, he is the "tri" of "tripartisan" because he is the only independent in the U.S. Senate.

So, you have Republican and Democrat for

bipartisanship, and when we talk about tripartisanship it includes Senator Jeffords. I have had the occasion to work with Senator Jeffords since he and I came together as Watergate babies, only most Watergate babies were Democrats, 74 out of 90 members of that new class. We were two of the 16 Republican members of that class. It has been a privilege to serve with you all these years in the Congress.

Senator Jeffords. And at that time we limped into Congress together, literally.

The Chairman. We did.

Senator Jeffords. You were on your crutches and I had a big back brace on because we were two survivors of the slaughter of Republicans at that time.

The Chairman. And I remember the Democrats pointed to us and said, we almost got those two. [Laughter].

OPENING STATEMENT OF HON. JAMES M. JEFFORDS, A U.S. SENATOR FROM VERMONT

Senator Jeffords. Prescription drugs. This is a wonderful time, and I am just so proud to be here with you, Chuck, and we will go on together. But I do have just a few comments to make, and I want to just make them.

The Chairman. Sure.

Senator Jeffords. The Prescription Drug and Medicare Improvement Act represents a landmark improvement of the Medicare program and, you and our friend Senator Baucus, we should owe you a lot.

The Chairman's mark provides for a comprehensive universal and portable prescription drug benefit under Medicare. It also pioneers new arrangements with private sector-based health plans that promise to integrate traditional medical interventions and disease prevention and chronic disease management. The drug benefit, in particular, though, meets four principles that have guided me through this effort.

First, this program provides a universal benefit and is available to all Medicare beneficiaries. While I believe it is critical to provide a benefit to the poor and those with catastrophic costs, all seniors,

regardless of income, will benefit from this plan.

Second, this program is comprehensive. Beneficiaries will have access to the best medicine. They will not be limited to only the cheapest ones for the sake of saving money.

Third, this Medicare drug benefit is affordable for both beneficiaries and the government. Finally, for a drug benefit to be truly successful, it must be sustainable.

It would do little good to repeat the catastrophic failure of years past by beginning a program that we cannot carry on. This program will combine seniors' contributions with government guarantee and will have the best chance of enduring for the future.

Mr. Chairman, I believe this bill meets these four standards. It is universal, it is comprehensive, it is affordable, and sustainable. Can it be improved? Probably. But this plan is a good compromise and I commend you for all the efforts that you and others put into this. Thank you.

The Chairman. Thank you, Senator Jeffords.

Now it is Senator Rockefeller's turn.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator Rockefeller. I congratulate all the people aforenamed, and all others who should have been named.

Mr. Chairman, I want to focus, since I only have a few minutes, on eight changes that I think we should make to make this a better bill.

Number one, there is a substantial gap in coverage in this mark. The gap has improved. It is still not enough improved. We should eliminate that coverage gap.

Two, I fundamentally disagree with the notion that we should pay private insurers more than traditional fee-for-service Medicare to deliver a drug benefit. If this is a free enterprise country, if Medicare is administered by costs at 2 or 3 percent and the private plans go between 8 and 12 percent, that means that they are not competitive.

I have no objection to private plans, but I think they need to be able to compete. That is harder for them to do because of their requirements. Either they are more efficient or they are not more efficient. Medicare beneficiaries should not suffer because of their insufficiencies, if they have them. There is no reason to pay them more than other providers.

All Medicare beneficiaries get the same benefit and should pay the same premium. That is pretty much of a standard argument over all the years. There should not be different benefits of premiums for Medicare beneficiaries based upon where they live, in West Virginia, Montana, New York, or California I feel very strongly about that.

Third, seniors who do not have access to a private insurer or who chose to stay in traditional Medicare, which will be the case in my State since no plan will come in and none exist, they should be able to receive the same catastrophic limit on their medical expenses, that is, all other expenses other than drugs.

Four, we should do our best to make sure that employers do not drop coverage because there is not sufficient incentive for them to continue providing it to their retirees. How could we do this? We could fix this by allowing employer contributions to count towards the out-of-pocket costs that seniors are paying.

Five, I am very concerned, as others are, about the fall-back in this proposal. I think it is very unstable. I think, as Senator Bingaman indicated, seniors are going to be very confused. You do not necessarily reach all seniors by e-mail. How are they going to know?

They are going to have to change pharmacies, doctors.

They will go back and forth, private plan, Medicare, fall-back, back and forth. Every year will be a different experience for them. I think that is artificial construction. It is like a new architectural building that does not work.

Seven, I think we should provide all seniors with a dependable Medicare guarantee of a prescription drug benefit. Is that old-fashioned? I do not think so. That is what seniors expect when we tell them we are giving them a Medicare drug benefit, and that is what they should get, even if some believe that private plans are the future of the program.

Private plans can be a part of the program. I think they should have to compete for it, others on this committee do not. But in any event, Medicare beneficiaries need to know that the program works for them now.

Finally, I really do object to the fact that this does not kick in, if it were to be passed, until the year 2006. As Senator Graham has pointed out, we started out Medicare in 1965. There were no computers, none of the technology. I think you said that it took about six months to get it going nationwide.

Now we have the prospect of easing past 2004, and then Medicare beneficiaries will think that if we passed

it here, now, or in the next several weeks, that it will become effectively immediately. It will not. It is a major deception of them and I think we ought to take at least one year off of that date, at least one year off of that date.

Thank you, Mr. Chairman.

The Chairman. I would be willing to start it sooner. We were just taking the best advice that we could get from various agencies of the Federal Government that predict and know something about the implementation of legislation. We are taking their advice on this. If it could be speeded up, I would be happy to do it, but I need better information than I have right now.

It is now Senator Graham's opportunity.

OPENING STATEMENT OF HON. BOB GRAHAM, A U.S. SENATOR FROM FLORIDA

Senator Graham. Thank you, Mr. Chairman. I want to commend you, Senator Baucus, and the others who have worked on this legislation. I particularly would like to thank you for including the Immigrant's Children's Health Improvement Act as part of the Chairman's mark. This will go a significant way towards assuring that all American children have access to health care.

I have two principal concerns about the mark. The first has been discussed already, and that is the level of funding and the expectations that seniors are going to have versus the reality.

The second, is the mandatory use of the private sector as a means of delivering the prescription drugs. Let me just mention why I am so concerned about that mandate.

First, an explanation. This chart talks about the choice that seniors have between traditional Medicare and various forms of managed care today. This line over here should be approximately six times bigger than this line over here because six times as many elderly elect to go into traditional Medicare than do into one of the managed programs.

But there should be also an indication that, when you get to this point where you are dealing with prescription drugs, there is no choice. Everybody who is in traditional fee-for-service, if there are two or more plans in your community, you are mandated to go into a private plan. The only way you have an alternative is if there are not two or more prescription drug plans.

Second, is there is no example of a stand-alone prescription drug plan in any aspect of American health care today. There are sound actuarial reasons why we do not have it in the federal employees plan, why the employees of the pharmaceutical industry do not have it, why nobody has it.

So, that raises the third question, is why do we want to experiment on 39 million older Americans, many of the most vulnerable Americans to serious health problems, as the first group to try this stand-alone prescription drug plan?

Fourth, there is no demonstrated savings, as Senator Rockefeller just pointed out. In fact, we are subsidizing the private plans at a rate higher than that which we are going to provide to traditional Medicare. There is the unpredictability, not only the unpredictability that you might in four years be in four different plans, but the unpredictability of what the

benefits are going to be.

We have lots of folks in my State who have come recently from someplace else. If they have been accustomed to a certain level of benefits and monthly premiums and deductibles, should they not have, as they do in every other aspect of Medicare today, some expectation of continuity once they are at a new home?

Finally, I think this is a major step towards what we have said we would not do, which is a privatization of Medicare. In fact, I think one of the principal motivations behind this is to move substantially in that direction so that the gap between where we will be should this legislation be adopted and what will be necessary for full privatization will be closed.

In my own closing, I think the question here today is, are we taking the most significant step to improve Medicare since it was adopted in 1965, or are we doing what we did in the late 1980s under the same representations of the most significant step since 1965, which was the ill-fated experiment with catastrophic care?

After just a few months of seniors actually experiencing what they were getting as opposed to the headline description, there was such massive revolt that Congress repealed catastrophic care. I think we need to

be cautious that we do not set up the same pattern with a prescription drug bill that seniors will find to be so unstable and so inadequately funded that there will be a second revolution.

Thank you.

The Chairman. Thank you, Senator Graham.

Now, Senator Lincoln?

OPENING STATEMENT OF HON. BLANCHE L. LINCOLN, A U.S. SENATOR FROM ARKANSAS

Senator Lincoln. Thank you, Mr. Chairman. I personally want to thank you, Mr. Chairman, for your leadership in this committee that has brought us today to the consideration of a bill to provide a prescription drug benefit under Medicare. I applaud your effort, and certainly your willingness to listen to each and every one of us, and to try and work with all of our concerns.

It has been a long road for many of us who have worked on this issue for years, but it has been an even longer road for America's senior citizens. From a State where we have a disproportionate share of elderly in our population, of that disproportionate share, the majority of them are low-income and over 60 percent of them live in rural areas where they are more difficult to serve and oftentimes more expensive to serve.

These seniors have watched their drug prices escalate while the government seems to put the brakes on its promises to help them out. That is why I want to thank all of my colleagues on the committee for their willingness to work towards a consensus, and hopefully a compromise, and to realize that there are improvements we can make, both here in the committee and when we move to

the floor.

Senator Graham has certainly done a tremendous job, but Senator Baucus and Senator Breaux, Senators Rockefeller, Snowe, and Graham have all certainly put a great deal of time into this issue, and I applaud all of my colleagues.

Mr. Chairman, I believe this bill today represents a positive compromise. Like all legislative products, I do not think it is perfect, but our seniors should not wait any longer. I think I have expressed the fact that they have been waiting the last 10 years or better is issue enough for us to really bring something to the forefront.

However, I do predict that there are going to be problems down the road with the proposal we are considering and I want to certainly plead with my colleagues that we will be willing to be open-minded as we move through this process to look at some of those problems and to try and work out those differences.

I want to commit to every senior citizen in Arkansas that I will fight to correct the problems that may arise, not only in this debate but in years to come, as we move forward in perfecting legislation that we want to be fair and equitable to all seniors in this country.

One of the problems that I foresee, Mr. Chairman, is the private delivery model. The insurance companies have

told us that they do not want to offer a prescription drug-only plan, and the Administrator of the Centers for Medicare and Medicaid Services has said such a plan does not exist in nature.

Quite frankly, I believe we have proven through both Medicaid and Veterans Benefits that what the government can do can be most cost effective in the manner with which they have done it. We have got great examples in both of those areas where we can do something in a more cost-effective manner.

The administrative costs of Medicare are 2 to 3 percent, while the administrative costs of private insurance plans are between 9 and 15 percent. That is a lesson for us to learn and certainly something we can pay attention to.

Additionally, since all the Medicare+Choice plans left Arkansas nearly two years ago and not a single one of them offered a prescription drug plan, I am not convinced that a private delivery model will work in some of our rural States like Arkansas and others.

That is why I am hopeful that we can extend the rural fall-back to at least two years to provide our seniors with some certainty that they will not find themselves flip-flopping back and forth among plans that they do not understand and they are not aware of what is going to be

available to them.

But, as I said, Mr. Chairman, I believe you have brought us a long way, and I am very appreciative of that. I think it is because you have been willing to listen to all of us and to try and work with each and every one of our concerns.

I appreciate, certainly, your patience in working with me and I look forward to today's debate. Thank you, Mr. Chairman.

The Chairman. Thank you very much, Senator Lincoln.

Now we go to Senator Smith, then Senator Santorum.

Go ahead, Senator Smith.

OPENING STATEMENT OF HON. GORDON SMITH, A U.S. SENATOR FROM OREGON

Senator Smith. Thank you, Mr. Chairman. Like others on this committee, our thanks to you and Senator Baucus, the Ranking Member, for working as you have in a bipartisan way to produce a bill that truly has a chance of becoming the law.

The test for each of us individually is going to be whether the perfect--at least our individual views of the perfect--will again defeat the good. I describe this bill as "good" because I think it is a very good beginning, and you have done it in a way that I believe is responsible and compassionate, and it is sustainable. So, my thanks to you for accommodating some of my priorities, specifically as it relates to low-income seniors.

Also, Mr. Chairman, I appreciate your willingness to work with many of us on concerns over rural health priorities in your mark. I, along with other members of this committee, have been working to provide equity for a host of rural providers for years. This bill goes a long way to improving quality of care and access to care for seniors living in rural areas.

So, I thank you, sir, and the Ranking Member, because

I think you have made it possible with this work product to assure that no senior should ever again lose their home because they lose their health. Thank you.

The Chairman. Thank you, Senator Smith.

Now, Senator Santorum?

OPENING STATEMENT OF HON. RICK SANTORUM, A U.S. SENATOR FROM PENNSYLVANIA

Senator Santorum. Thank you, Mr. Chairman. I will be brief. I know people have been here a long time. I just wanted to congratulate you and thank you and Senator Baucus, Senator Breaux, Senator Frist, and others who were very instrumental in putting this package together.

I, too, want to echo some of the thoughts here about this being a marriage of the best of what the public sector can do and the best of what the private sector can do.

It does do some things to, I would argue, dramatically improve the quality of care by having coordination of care, an integrated benefit, particularly in the PPO and other models, the more managed models, I think, is absolutely essential to get better health care for our seniors.

I do not think that is talked about as much as it needs to be. That is a very big step forward for the management of care for our seniors, and I am very grateful that the mark here has that much-needed improvement to the Medicare system.

I, too, have some concerns. Many of them have been voiced here about the stand-alone Medicare prescription

drug benefit, maintaining the fee-for-service prescription drug benefit.

I think I have made it very clear, I would like to see a lot more incentives for people to move into coordinated care models where there is an integrated benefit, because I think it results in better efficiency, and importantly, maybe most importantly, better quality care.

I think that is what we should be focused on, getting the best for the taxpayers' dollars and the best for the Medicare recipient. I think we accomplish that by getting people into the same insurance programs that every other American in the private sector has.

I am 45 years old and I do not remember fee-for-service medicine. There is a reason it does not exist in America, because it is not a very good way to provide health care. But that is the traditional Medicare system that we maintain with this bill, and I understand that, because we do not want to change anything from seniors who are used to that system. But that is not the best way to deliver health care. It is not the most efficient way and it is not the highest quality way.

If we really are concerned about providing good, quality health care for our seniors at the best and fairest price for the taxpayers, as well as them, because

they pay for a lot of this, too, we really should look to create more incentives for people to go into those better models.

I understand this was a compromise, and it is a compromise I will support. But I firmly believe we owe it to seniors to try to work on this bill to do a better job in improving the quality of health care for our seniors going forward, and I would argue that that is one of the big challenges before us yet to have accomplished.

Finally, I just want to thank the Chairman. Pennsylvania has a very strong prescription drug program. The Chairman has been very good in working with us to make sure that those of us who have States who have very extensive prescription drug benefit programs will be partners at the table in providing those benefits for our States.

So, I thank the Chairman for his willingness to work with me in designing a program that we in Pennsylvania can live with. Thank you, Mr. Chairman.

The Chairman. Thank you, Senator Santorum.

Now, Senator Nickles?

OPENING STATEMENT OF HON. DON NICKLES, A U.S. SENATOR FROM OKLAHOMA

Senator Nickles. Mr. Chairman, thank you very much. I want to compliment you on putting this bill together and the fact that we are having a mark-up. Last Congress, we had a lot of meetings, but we did not have a mark-up. We had a mark-up on the floor and it was not productive, it was not successful.

I think, as a result of your efforts and leadership, we will have a mark-up, we will be successful, and we will pass a bill.

I have always wanted to include prescription drugs as a benefit for Medicare. I have also wanted it to be acceptable, affordable, and feasible for the future.

I do have some concerns about the cost of this bill, so I am delighted we are going to go through the walk-through. I am going to ask some questions. I have not decided what I am going to do on this bill. I want you to be successful and I want the Majority Leader to be successful.

Both of you have put an enormous amount of time on this, and the President. You want this to become law, and I appreciate that.

I also want it to be affordable for future

generations. We have a $13.3 trillion unfunded liability on Medicare today, two or three times the size of the unfunded liability on Social Security.

This bill is going to make it a lot worse. It is going to increase it by trillions of dollars. We are very generous in the benefits. I happen to believe we are probably too generous in the benefits, and I think you only go one way.

In other words, I do not think the co-pays are high enough. I will be very direct. I have an amendment and will decide whether or not to offer it. But we are starting out, and I will ask staff, but we are saying for 40 percent of Medicare eligibles, that the most that they will ever pay is 10 percent.

That is a very high place to start. That is a very high place to start. You could start at 80/20 or something and maybe go to 90, but it is kind of hard to start at 97 and then go to 90, or start at 95 and then go to 90.

I am afraid, with that small of a co-pay, and the people I am talking about, most of which do not have any premium, any deductible, that is going to lead to a lot of utilization, and maybe over-utilization.

I am concerned about this not costing 400. I will tell my friends at CBO, I am concerned about this costing

800. We will find out. We will find out what it will cost over the next 10 years.

I know estimates by both CBO and OMB, and some of the best actuaries in the world are making estimates, and they score it around $400 billion. But I am concerned it is going to cost a lot more than that.

I am concerned that we are light on reforms. We did not do balanced billing. We do not have concurrent retirement age. We did not take the basic Medicare program and have greater subsidies for the lower income, less subsidies for higher income.

One other thing, Mr. Chairman. The main reform element we have in this bill is PPOs. I think we need to work on that substantially to have the PPO be a viable, successful alternative.

If not, I am afraid we are creating and building a system that may not be financially affordable for future generations. We are going to basically double the number of Medicare beneficiaries in the next 10 years, or the next 30 years, and I want our kids to be able to afford this system as well.

So, anyway, my compliments to you. I look forward to working with you and hopefully coming to the conclusion that it is affordable for future generations. Thank you, Mr. Chairman.

The Chairman. Thank you, Senator Nickles.

One of our members, Senator Kyl, is in mark-up in Judiciary. He asks if he could have a couple of minutes when he could get here with us to make an opening statement.

Senator Nickles. If you would like, I have listened to him enough, I could give that for him. [Laughter].

The Chairman. Well, I would be glad to listen to you for him, but I would like to have you get his approval.

So we are done with opening comments, except for Senator Kyl, then. So why do we not now go, as Senator Baucus and I had planned, to Linda Fishman, our staff, and other staff who have a reason to help her out, to do first of all what we would call a walk-through, which is an explanation of the modification.

Then at the end of that explanation--and this is open for questions from members to her--we would then adopt that modification and then we would go through the walk-through of the underlying mark.

So would you please proceed, then?

Ms. Fishman. Thank you, Senator Grassley. This Chairman's modification to the Prescription Drug and Medicare Improvements Act of 2003 is at your seat. The document is stapled and it looks like this.

Title 1, "Medicare Prescription Drug Benefits," Section 1860(d)(5), "Beneficiary Protections," which is on page 5 of the mark-up document. This change clarifies, the appeal process would include a grievance in the appeals process as under Medicare+Choice.

Section 1860(d)(6), "Prescription Drug Benefits," on page 7, in 2006, standard coverage would be defined as having a $275 deductible, 50 percent cost sharing for drug costs between $276 and the initial coverage limit of $4,500, then no coverage, except that beneficiaries would have access to negotiated drug prices until the beneficiary had out-of-pocket costs of $3,700 and 10 percent cost sharing thereafter.

The limitation on the deductible in out-of-pocket expenditures would be the same as under standard coverage.

On page 14 of the mark-up document, and this is not listed in the Chairman's modification document, on page 14 there is an error in the year. The risk corridors would be modified for the years 2008 to 2011. I believe it say 2007 in the mark-up document.

Section 1869, "Premium and Cost Sharing Subsidies for Low-Income Individuals," which is on page 16. Eligibility for low-income individuals would be determined by States in the Social Security

Administration.

A BIPA requirement that the Commissioner of Social Security would identify and notify individuals entitled to benefits under the Medicare savings program would be amended to include individuals eligible for low-income assistance under Part D.

Senator Nickles. If I could interrupt. What are we doing there, just in English? I can read it, but what are you trying to do?

Ms. Fishman. The Social Security Administration would be able to identify the eligibility of these individuals for the low-income benefit.

Senator Nickles. So they would send a notice to them or something?

Ms. Fishman. Yes.

Senator Nickles. These would be SSI individuals?

Ms. Fishman. They can apply at the Social Security Administration for these benefits as opposed to going to the Medicaid office.

Senator Nickles. All right.

Ms. Fishman. New section. On page 18, Medicaid Coverage Maintenance. Any State that has above-expanded coverage above the minimum income level for low-income Medicare beneficiaries for aged, blind and disabled Medicaid coverage would have the Federal Government

assume the cost of Medicare Part A cost sharing for the beneficiaries that fall into the expanded eligibility category.

The Part A cost would be assumed so long as the State maintains the expanded coverage. This provision would only be applied to States who have expanded eligibility levels prior to the enactment of this legislation.

Senator Nickles. Are you getting ready to move on?

Ms. Fishman. Yes.

Senator Nickles. I do not want you to move on just yet.

Ms. Fishman. All right.

Senator Nickles. Correct me if I am wrong, but almost all States, in Medicaid, have expanded coverage above present law.

Ms. Fishman. I believe that is true.

Senator Nickles. I mean, Medicaid goes to, what, 74 percent?

Ms. Fishman. Yes.

Senator Nickles. But a lot of States cover up to?

Ms. Fishman. One hundred percent of poverty.

Senator Nickles. One hundred percent, and some maybe 135.

Ms. Fishman. There are 19 States who go up to 100 percent of poverty.

Senator Nickles. All right. And some States above that?

Ms. Fishman. No, not on duals.

Senator Nickles. Just up to 100. Then we are saying, if those States do more, we are assuming that the Federal Government is going to assume what?

Ms. Fishman. The Federal Government is ensuring that the States keep up a maintenance of effort by picking up the costs of the Medicare Part A cost sharing in order to keep them having these individuals on the rolls receiving these benefits.

Senator Nickles. All right. But in Medicare where you have a federal/State share, an average would probably be, what, about 57 percent federal, something like that?

Ms. Fishman. Yes.

Senator Nickles. So the States have opted to cover additional individuals at a higher level. We are saying, to reward them for doing that or to make sure they do not reduce that group of people, we are going to what?

Ms. Fishman. Assume the cost of Medicare Part A cost sharing for those beneficiaries that fall into that expanded eligibility category.

Senator Nickles. All right. But right now, those people are under Medicaid, right?

Ms. Fishman. Yes.

Senator Nickles. And they are also eligible for Medicare, but they do not receive Medicare.

Ms. Fishman. Under this proposal, that is correct.

Senator Nickles. How much does this cost? I am trying to figure out what you are doing.

Ms. Fishman. It is $3.5 billion over 10 years.

Senator Nickles. This is Senator Kennedy's provision where he was wanting to make sure we did not have a reduction in Medicaid?

Senator Hatch. No, this is my provision.

Senator Nickles. That is a frightening thing.

The Chairman. I have had two members of this committee talk to me about this, one was Senator Santorum and the other one is Senator Hatch, because I believe this was affecting your States.

Senator Hatch. That is right.

Senator Nickles. It may affect all the States. I am just trying to figure out what we are doing. So you have no reduction in Medicaid services, but Medicare is going to pick up Part A.

Ms. Fishman. The cost of the Medicare Part A cost sharing.

The Chairman. I would like to have Senator Santorum, if we could, explain from his point of view, and Senator Hatch's point of view, the importance of this

to your States.

Senator Santorum. The concern that I have is that you have States that are in very tough budget times, that with this expanded benefit, may be encouraged to frankly pull off and not continue their expanded coverage, which may end up costing us a lot more money, having these people who are now on Medicaid fall back on Medicare.

So, from my perspective, this looks like a nice sweetener to keep people doing what we want them to do, which is not add to our cost load. I tried to find out from HHS if they had any kind of guess as to how many States would do it, and obviously they do not know. We are guessing.

But my concern is, if we do not create some sort of sweetener for the States to continue their Medicaid program at these higher levels, now that we have expanded the benefits under Medicare, there is a chance these States may say, hey, look, they have got a full benefit, we do not need to keep covering them, let them go onto Medicare, and that is now 43 percent of costs that we do not have to incur at all because they are on a 100 percent federal program.

So I thought this was actually a smart expenditure of money to keep people maintaining effort at a time when States are looking for places not to maintain effort. I

could be wrong on that, but I think it is a wide trade-off.

The Chairman. Senator Hatch?

Senator Hatch. Well, it is to reward States that are picking up people above 74 percent and taking it off our backs. To be honest with you, there ought to be a reward for that. We included a provision which would reward the 19 States that cover individuals over 74 percent of the federal poverty level in their State Medicaid programs.

The Medicare program would pick up the Medicare B premiums and the Medicare Part A cost sharing for these States' QMB populations. As I understand it, that is up to 100 percent of the FPL, the federal poverty level.

In other words, the States which cover individuals--tell me if I am wrong--over 74 percent of FPL in their Medicaid coverage would have the Federal Government pay for Medicare Part A cost sharing for those between 74 percent and 100 percent of the federal poverty level. It seems to me that is a good incentive to put into this bill

The Chairman. Proceed, Ms. Fishman.

Senator Daschle. Mr. Chairman, I had a question about the benefit as well.

The Chairman. Senator Daschle, please proceed.

Senator Daschle. Thank you.

As I understand it, the mark lets the plans define the benefit. Is that correct? So as you describe the benefit, what variations might you expect in the benefit itself, given the flexibility that the plans have to define what the benefit is?

Ms. Fishman. When we go through the mark-up document, the mark-up document states that there will be a standard benefit and then there will be flexibility around the design of that benefit, as long as it is actuarially equivalent to the standard benefit.

Senator Daschle. So it has to be actuarially equivalent, but it can vary from different regions of the country and could have different benefits. Is that correct?

Ms. Fishman. Well, the value has to be the same throughout the Nation.

Senator Daschle. Could the deductible vary?

Ms. Fishman. No.

Senator Daschle. And as you describe the requirement for similarity actuarially, what within actuarial constraints would allow a difference in the benefit? What would be an example of that?

Ms. Fishman. For example, the deductible cannot be varied. However, the cost sharing between, say, $276 and the $4,500 initial benefit limit could be less or more

than 50/50 cost sharing that is defined in the document as the standard cost sharing within that initial benefit limit.

Senator Graham. Mr. Chairman? Mr. Chairman?

The Chairman. Senator Graham?

Senator Graham. I have got two questions, going back to the issue of the 19 States which are currently----

Senator Breaux. Bob, can I just a follow-up just on his point?

Senator Graham. All right.

The Chairman. Senator Breaux?

Senator Breaux. Just real quickly, on Senator Daschle's questions about the variation, any variation that is in a plan, though, would be subject to having it be approved by Health and Human Services, is that not correct?

Ms. Fishman. That is correct.

Senator Breaux. All right. Thank you.

The Chairman. Now, Senator Graham.

Senator Graham. I want to understand the issue of the 19 States that are now providing benefits above the 74 percent level. Would this federal assistance to those States cover all of the services or just the prescription drug service?

Ms. Fishman. It is just the Part A cost sharing that is not related, necessarily, to the prescription drug piece of this.

Senator Graham. Mr. Hayes has a questioning look on his face. Am I correct that the proposal here is that for the lowest income bracket--and there are three low-income brackets, that those people would not be eligible for Medicare benefits, but rather their benefit schedule would be the Medicaid schedule?

Dr. Fowler. Only the full dual eligible, those fully eligible for Medicaid, would remain on Medicaid. The QMBs, the SLMBs, and the QI-1s would be part of the Medicare benefit.

Senator Graham. How are those dual eligibles currently treated?

Dr. Fowler. Well, currently they are under Medicaid.

Senator Graham. Medicaid?

Dr. Fowler. Yes, they are under Medicaid, except for Medicare benefits. They receive their Medicare benefits and then the State would wrap around through Medicaid to cover the additional.

Senator Graham. But instead of receiving the Medicaid benefits with the Medicaid wrapping around, picking up things like co-payments, deductibles, et

cetera, we are now going to have the Medicaid benefits available for that.

Dr. Fowler. That is right.

Senator Graham. What is the estimate of the relative value of the current system, Medicare benefits with Medicaid wrap-around, and the value of the benefits under the Medicaid program?

Dr. Fowler. Well, Medicare covers approximately 50 percent of the costs of your services or 50 percent of spending. Medicaid is much more generous and it covers things that Medicare currently does not cover, for example, long-term care and prescription drugs. I do not know how to describe the percent of spending that is covered under Medicaid.

Senator Graham. What is the rationale of using Medicaid as opposed to the current system which uses Medicare with the Medicaid program picking up beneficiary costs?

Dr. Fowler. Well, at least as we were exploring this issue, one of the issues was whether the poorest and the sickest would be appropriately treated under private plans or whether it would be more appropriate to leave them where they were, that is, covered by State Medicaid programs.

We tried to develop all sorts of protections under

the private plans to make sure they were not subject to some of the more austere requirements that might prohibit them from getting needed drugs, but in the end we found that approach to be administratively difficult.

The Congressional Budget Office estimated that there would be additional costs of that approach. There was concern about these beneficiaries affecting the risk pool for the rest of the Part D benefit.

Senator Graham. Mr. Chairman, I will not pursue this further, other than I have a letter from the National Governors Association which raises questions about this provision. When we get further into the walk-through, I'm going to want to return to this.

The Chairman. Yes, we will be glad to call on you for that purpose.

Senator Hatch had a follow-on of comments that he made, so I would call on him at this point.

Senator Hatch. After the Senator from Florida's comments, I just wanted to point this out and ask if this is true. Dual eligibles are the poorest of the poor and are typical, under 74 percent of the federal poverty level. They are eligible for both Medicare and Medicaid coverage and receive drug coverage for the Medicaid program. Am I right so far?

Dr. Fowler. Yes.

Senator Hatch. All right. Now, the Finance legislation keeps the dual eligibles in the Medicaid program primarily because it would cost billions of dollars, as much as $40 billion per year, to move them completely over to the Medicare program.

Am I right on that?

Dr. Fowler. It is $40 billion over 10 years.

Senator Hatch. That is right. I thought it was $40 billion. Over 10 years? I think it is $40 billion a year, is it not?

Dr. Fowler. It is $40 billion over 10 years.

Senator Hatch. Over 10 years. All right.

Dr. Fowler. Assuming no claw-back.

Senator Hatch. All right. But as I understand it, dual drug spending alone is estimated to be over $16 billion. Am I wrong on that? I think I am right on that.

Ms. Fishman. Correct. Yes, that is correct.

Senator Hatch. Well, that is my point. Now, some have argued that the Finance bill has created a two-tiered system for the dual eligibles because they would remain in the Medicaid program.

States are concerned about the expense of continuing to provide care for the dual eligibles because they are experiencing serious fiscal constraints at this time.

So, it is important to recognize that the Medicaid program is a federal/State government matching program. The Federal Government makes significant contributions to the State Medicaid programs.

Now, the Finance Committee is also giving States $14 billion, as I understand it, over 10 years to federalize the cost of the Medicare Part B premiums for QMBs and Medicaid beneficiaries between 74 percent and 100 percent of the FPL. Is that correct?

Dr. Fowler. Yes.

Senator Hatch. All right. That is correct.

In addition, the Finance Committee legislation includes this provision which would reward the 19 States that cover individuals over 74 percent of the FPL in their State Medicaid programs.

So the Medicare program would pick up both the Medicare B premiums and the Medicare Part A cost sharing for these States' QMB populations, the poorest of the poor. In other words, those States which cover individuals over the 74 percent are actually saving the Federal Government money and therefore are going to get some help through this provision.

Dr. Fowler. That is right.

Senator Santorum. Mr. Chairman?

The Chairman. First of all, Senator Rockefeller had

asked for the floor, then I will call on you, Senator Santorum.

Senator Rockefeller. Mr. Chairman, I have a series of questions that I want to ask. Although I respect the panel very much, I want to ask them to CBO.

The Chairman. Yes. We have CBO here. I would ask Mr. Doug Holtz-Eakin, the Director, if he could come to the table. We do not have your name up there, but we can take care of that shortly.

Senator Baucus. We can get it.

The Chairman. Now your name is coming so you will be an official part of this ceremony.

Senator Rockefeller. Thank you, Mr. Chairman.

Senator Baucus. I do not know if you want to come to the table, Tom, but your name is up here, too. You might as well. We are going to have questions, I am sure.

The Chairman. Mr. Lieberman, if you need to be at the table, we can get an extra chair for you.

Now, you want to ask your questions later, is that right?

Senator Rockefeller. Yes.

The Chairman. Now I would go to Senator Santorum.

Senator Santorum. My question is on this provision. What does maintaining effort mean? Do they have to maintain their current program or can they play games

with us on this maintenance of effort?

Ms. Fishman. There are certain minimum standards they would have to meet, if you would like to know them.

Senator Santorum. At some point I would.

Ms. Fishman. Yes. They cannot play games. There are minimum standards that we can talk about when we walk through the mark-up document.

Senator Santorum. All right. Very good. Thank you.

The Chairman. All right. Would you continue? Now, we are still on the walk-through of the modification.

Ms. Fishman. Right. That is correct.

The Chairman. Yes.

Ms. Fishman. Number 4 on page 2 is the Trustees Report on Medicare's Unfunded Obligations. This provision requires the Board of Trustees of the Federal Hospital Insurance Fund and the Federal Supplementary Medicare Insurance Trust Funds to include in their 2004 annual report an analysis of the Medicare program's total unfunded obligations.

This provision would require the Trustees to include an analysis of the program's long-term obligations compared to the program's dedicated funding sources, not including general revenue transfers. This would include the combined obligations of the HI Trust Fund, the SMI

Trust Fund, and the new prescription drug account.

There is a new section added on page 20 entitled, "Study on a National Medicare Prescription Drug Premium." This provision would require a study to look into payments to prescription drug plans being geographically adjusted in a budget-neutral manner to account for differences in utilization across service areas.

Section 104 under the Medicaid amendments on page 22. This modification would provide $30 million to Puerto Rico and the territories to help provide prescription drugs for low-income seniors. This allocation would be indexed annually by prescription drug spending.

Senator Baucus. Linda, where are you in your mark? What page on the modification?

Ms. Fishman. On the Chairman's modification document, I am close to the bottom of page 2, under Section 104.

Senator Baucus. Thank you.

Ms. Fishman. Section 1807(a), "Transitional Prescription Drug Assistance Card Program for Eligible Low-Income Beneficiaries," on page 25 of the mark-up document.

This modification clarifies that the entire $600 benefit would be available for the entire year. In addition, any balance left on the card in year one could

be carried forward.

Title 2, "Medicare Advantage," Section 201, "Establishment of the Medicare Advantage Program," on page 32. To enroll in a Medicare Advantage plan, beneficiaries must be entitled to Part A and enrolled in Parts B and D.

Medicare Advantage plans include county-based coordinated care plans, private fee-for-service, and medical savings account options, as well as regional preferred provider organizations, or PPOs.

The modification would all beneficiaries who choose a private fee-for-service plan to forego enrollment in Part D and still participate in this option under Medicare Advantage.

Section 202, "Benefits and Beneficiary Protections," on page 33 of the mark-up document, "Providing Consumer Protections in Health Plan." This provision would give the Secretary the authority to disapprove a health plan's bid for the Medicare Advantage if the Secretary determines that the deductible, co-insurance, or co-payments applicable under the plan discourage access to covered services.

Under consumer education and counseling, there is a modification that would provide reliable, more adequate funding of existing State health insurance ombudsman

advice and counseling services.

The Secretary would transfer $1 per Medicare Part A, B, or C enrollee into a consumer ombudsman account. This account would be authorized to be appropriated for purposes of funding the State Health Insurance Program counseling programs established by Section 4360 of OBRA 1990.

There is a new section added on page 38 called "Expanding the Work of Medicare Quality Improvement Organizations in the New Medicare System."

This provision would expand the Medicare Quality Improvement Organizations, or QIOs, in the new Medicare system. It would provide that the Medicare QIOs' responsibility be amended to include new sections of Medicare that create Medicare Advantage plans, Medicare prescription drug plans, and the prescription drug assistance cards. QIOs currently have responsibility for beneficiary protection in clinical improvement in all other parts of the system.

Access to basic outpatient prescription drugs claims data and the authority to work with the Medicare Advantage plans would complete their ability to improve the quality of care for Medicare beneficiaries across the entire continuum of care.

Title 4, "Medicare Fee-for-Service Provisions."

Section 401, "Equalizing Urban and Rural Standardized Payment Amounts under the Medicare Inpatient Hospital Prospective Payment System" on page 48. The Secretary would compute an equal standardized amount by fiscal year 2005 and thereafter.

Senator Rockefeller. Ms. Fishman?

Ms. Fishman. Yes.

Senator Rockefeller. If I may ask a question.

Ms. Fishman. Yes.

Senator Rockefeller. I do not mean to seem picky about this, but it is sort of the whole question of honesty in presentation.

You are using the word "Medicare Advantage" and it is printed throughout here. What you are really talking about is Medicare+Choice. All across America, people understand that.

Ms. Fishman. No. The Medicare Advantage program is the new name, which includes Medicare+Choice plans, the new preferred provider organizations, private fee-for-service plans, and medical savings accounts.

Senator Rockefeller. All right.

Ms. Fishman. It is an umbrella name for what used to be a more narrow Medicare+Choice name and has now expanded to include more organizations.

Senator Rockefeller. Thank you.

Ms. Fishman. Section 402, "Adjustment to the Medicare Inpatient Hospital PPS Wage Index."

Senator Conrad. Could I just go back to the previous point that you were on on Section 401?

Ms. Fishman. Yes.

Senator Conrad. That is a change. It was previously 2004, and now that has been changed to 2005.

Ms. Fishman. Yes.

Senator Conrad. What was the reason for that change?

Ms. Fishman. The reason for change is the scoring issue of not having budget money to spend in FY 2004.

Senator Conrad. So there is no money available in 2004.

Ms. Fishman. My understanding is, there is not money in 2004. We have tried to pay for many of these provider provisions with reductions in spending elsewhere in the program, but have not been able to accrue enough savings to accomplish all of our provider adjustments in the year 2004.

Senator Conrad. All right. Thank you.

Ms. Fishman. You are welcome.

Section 402, which is the adjustment to the Medicare inpatient hospital PPS wage index, to revise the labor-related share of the index. This is on page 48. The

percentage decreased.

The labor-related share would continue to be 68 percent of the standardized amount, and then to 62 percent for cost reporting periods beginning on or after October 1, 2004. This would not be applied in a budget neutral manner.

Section 404, "Fairness in the Medicare Disproportionate Share Hospital (DSH) Adjustment for Rural Hospitals." That is on page 50. Starting for discharges after October 1, 2004, a hospital that qualifies for a DSH adjustment when its DSH patient percentage exceeds the 15 percent threshold, would receive the DSH payments using the current formula that establishes the DSH adjustment for a large urban hospital. A PIKL hospital receiving a DSH adjustment under the alternative formula would not be affected.

Next, there is an error, correction, or modification in something that is not in your document. This concerns the physician GPCI issue.

The Secretary would be required to increase the value of the work geographic index to 0.980 in 2004. For 2005, the values for work, practice expense, and malpractice's geographic indices would be increased to 1.0 for three years, through the year 2007.

Section 413, "An Increase in Renal Dialysis Composite

Rates for Services Furnished in 2003 and 2004," on page 56. The change is that the composite rate would be increased by 1.6 percent for services furnished in 2005 and 2006.

Section 414, "Interim Payments----

Senator Conrad. Can we stop you on that point as well?

Ms. Fishman. Yes.

Senator Conrad. Mr. Chairman?

The Chairman. Yes.

Senator Conrad. This also is a change. Previously, it was adjustments in renal dialysis--I know Senator Santorum has an interest in this issue as well--for 2004 and 2005. Now it is 2005 and 2006.

What is the reason for that change?

Ms. Fishman. Again, it was a budgetary decision. Not being able to have spending in the year 2004, we moved it a year out.

Senator Conrad. Maybe we could just make note of this, Mr. Chairman and members of the committee. This is something that is going to affect a lot of people. Hopefully before we conclude our work, or perhaps before we get to the floor or when we are in the full Senate, we might be able to find a way to go back to where we were on this issue.

Senator Santorum. Mr. Chairman?

The Chairman. Yes, Senator Santorum?

Senator Santorum. Mr. Chairman, I just want to join Senator Conrad. I am not happy that this provision was moved back. I understand that for 2004 there are big funding problems with the budget, and I understand the reason for this.

There are other alternatives that we have put on the table that could work our way around this problem, and I would hope the committee would be willing to work with us, having to do with getting a full market basket update, which is really what would be preferable as opposed to just a flat increase here. We would like to engage the committee on that issue, whether it is now or on the floor, and would appreciate your cooperation.

The Chairman. As the author along with Senator Baucus of these provisions, and all of interest in rural equity, I want to help with that as well. I just wonder if Senator Nickles, as chairman of the Budget Committee, would explain the situation on not having budget authority for 2004. I think it relates to our unemployment compensation legislation that we passed.

So we do not have, in trying to take care of another problem of the unemployed under the jurisdiction of this committee, the leeway for 2004 that we anticipated when

this same amendment went through the Senate 85 to 12 as part of the tax bill.

So obviously, all of us in this committee from rural America are interested in these issues. We will try to find a solution as best we can, but right now we have made these fine-tuning adjustments to take care of a problem we have created ourselves.

Ms. Fishman?

Ms. Fishman. Section 414. This is on page 57 of your mark-up document. "Interim Payments and Study for Covered Outpatient Drugs and Biologics."

With respect to covered drugs and biologics furnished in hospital outpatient departments, CMS is directed to commission a new, independent survey of hospital acquisition costs on a per-product basis, to report the survey findings to Congress, and to consider those findings in establishing annual reimbursement rates for such drugs and biologics.

On an interim basis until 2006, the provision would establish product-specific reimbursement rates for single-source, innovator multi-source, and non-innovator multi-source products.

Section 416 on page 58 of the mark-up document entitled, "Increase for Grant Ambulance Services Furnished in a Rural Area." The payment for grant

ambulance services originating in a rural area or a rural census track would be increased by 5 percent for services furnished on or after January 1, 2005 through December 31, 2007. These increased payments would not affect Medicare payments for covered ambulance services in subsequent periods.

Section 418, "Treatment of Certain Clinical Diagnostic Laboratory Tests Furnished by Sole Community Hospital" on page 59. Sole community hospitals that provide clinical diagnostic laboratory tests covered under Part B in 2005 and in 2006 would be reimbursed the reasonable costs of furnishing the tests.

Section 419, "Improvement in Rural Health Clinic Reimbursement Under Medicare." It's on page 60 of the mark-up document. The rural health clinic upper payment would be increased to $80 for calendar year 2004. The medical economic index applicable to primary care services would be used to increase the payment limit in subsequent years.

Section 421, the "Freeze in Payment for Items of Durable Medical Equipment and Certain Orthotics," page 61 of the mark-up document. Class III devices would be exempt from the durable medical equipment freeze.

Section 422, the "Application of Co-Insurance and Deductible for Clinical Diagnostic Laboratory Tests,"

page 61. This provision would require Medicare to pay all clinical laboratories 80 percent of the applicable fee schedule.

Hospital-based physician's offices and independent clinical laboratories would be able to charge beneficiaries a 20 percent co-insurance amount. The Medicare Part B deductible would apply to all tests furnished across all settings. The provision also strikes the comptroller general's study in the original Chairman's mark.

Section 423, "Basing Medicare Payments for Covered Outpatient Drugs on Market Prices," on page 62 of the mark-up document. Section 423(a), "The Medicare Payment Amount." There was a typographical error.

The second sentence of that provision should read, "After January 1, 2004, existing drugs would be paid the lower of the AWP, or 85 percent of the listed AWP as of April 1, 2003.

This provision saves Medicare $16 billion over the 10-year period and would save Medicare beneficiaries approximately $8 billion through lower cost sharing and lower Part B premiums.

Section 423(b), "Adjustments to Payment Amounts for the Administration of Drugs and Biologicals." During 2005, the end-stage renal disease composite rate would be

increased by 0.05 percent per year beginning in 2006 and subsequently the ESRD composite rate of the previous year calculated without the temporary increase specified earlier in this legislation would be increased by 0.05 percentage points.

Senator Nickles. Mr. Chairman?

The Chairman. Senator Nickles?

Senator Nickles. I would like to ask a question. In Section 423, the payment amount, you reduced the payment for some specialty drugs. I believe those are primary oncology or cancer drugs.

Ms. Fishman. Yes.

Senator Nickles. The oncologists, I think many of whom said that they were supportive of that, but they also were hoping that there would be some adjustments. They were making money on the drugs, but they were under-financed or reimbursed for some of their fee schedules.

Were those adjusted elsewhere?

Ms. Fishman. Yes. You will see in the mark-up document that we will present later that there are numerous adjustments to the payments that oncologists receive. Actually, in the next new section we will talk about an additional adjustment we have made to benefit oncologists and other physicians who administer these drugs.

Senator Nickles. All right. Thank you.

Ms. Fishman. Section 423(b) is an adjustment to payment amounts for the administration of drugs and biologicals. It is a new section.

I will skip right to the explanation of the provision. The provision would authorize the Secretary to compensate physicians for chemotherapy drugs that they purchase with a reasonable intent to administer to a Medicare beneficiary, but which cannot be administered despite the physician's reasonable efforts.

For example, if the beneficiary is too sick or the beneficiary's condition changes and the physician must discard the drugs, the Secretary could increase the Medicare payment amount, but not including beneficiary cost sharing across the board for all chemotherapy drugs paid by Medicare, but the total amount of the increase could not exceed one percent of the payment for chemotherapy drugs.

Section 423(c) is a linkage of revised drug payments and increases for drug administration. The explanation of the provision reads, "The Secretary shall not implement the revisions in payment amounts specified in Subsection A for a category of drug or biological unless the Secretary concurrently implements the adjustments to payment amounts for administration of such category of

drug or biological, as specified in Subsection B."

New section, page 72. This is a clarification of congressional intent in the Balanced Budget Act of 1997, or BBA, with respect to graduate medical education and a technical correction.

Senator Breaux. Mr. Chairman?

The Chairman. Senator Breaux?

Senator Breaux. Let me just observe the fact that we have been through three pages now of reimbursements. I mean, we are fighting over whether we are going to increase reimbursements in one area by 0.05 percent or whether we are going to increase reimbursement for another provider by 1.6 percent.

All of these things that we have just been through points out the need for why this bill is so important to create a new system. Under Medicare Advantage, we will not be doing this.

We will not be price fixing in the minutiae that we are doing right here, where I daresay not many of us--certainly I do not--understand whether 1.6 is the right number, or whether it should be 2.6, or 0.07, or whatever. That is why it is so complicated now.

Under the new Medicare Advantage, the preferred providers will do negotiations with providers and get the best deal they possibly can in a competitive system. I

mean, what we do now, I think, is unsustainable. You just went through the last three pages that makes that point very well.

The Chairman. Proceed.

Ms. Fishman. This new section on page 72 of your mark-up document would clarify that to receive direct graduate medical education and indirect medical education payments for residents in non-hospital locations, hospitals must incur all, or substantially all, of the costs of the training in that site from the effective date of a written agreement between the hospital and the entity owning or operating the non-hospital site.

The provision would also clarify congressional intent was for all, or substantially all, of the costs of the non-hospital site, to include resident stipends and benefits and other costs, if any, as determined by the parties and to allow programs to be eligible for graduate medical education funding if the hospital incurs all, or substantially all, of the cost of training in the non-hospital location, even if for certain programs all, or substantially all, of the costs might be low because of voluntary faculty or other discounted benefits.

Finally, this provision would provide for a technical amendment to provisions enacted in the 1997 BBA that created a three-year rolling average and counting

residents in a one-year lag in increasing IME payments. It would exempt dental and podiatric residents from these provisions in the same way these residents were exempted from the residency requirements in the Balanced Budget Act.

The Chairman. Linda, I might suggest to you, I would like to get through this before we go to vote. Maybe you could just highlight each of them. Everybody has got it in front of them. Then maybe they can quickly break in if they have got a question.

Ms. Fishman. All right. Senator Grassley, we have split the work up, so Dr. Fowler will now continue.

The Chairman. All right. Well, then would you please do according to what I just suggested?

Dr. Fowler. Yes. Absolutely.

A new section was added on page 72, "Medicare Puerto Rico Hospital Payment Parity." This provision would increase the blended payment rate for Puerto Rico hospitals to 100 percent of the federal rate for five years. Current law would resume in fiscal year 2010.

New section added on page 72. "Use of Arrangements----"

Senator Baucus. Excuse me, Liz. Where are you in the mark-up document?

Dr. Fowler. Page 8.

Senator Baucus. Page 8. Thank you.

Dr. Fowler. Middle of the page.

"Use of Arrangements to Provide Core Hospice Services Under Certain Circumstances." This provision would permit a hospice organization to subcontract for core services under limited circumstances.

New section added on page 72, "Clinical Psychology Training." This provision would provide payments for costs of approved education activities of clinical psychology internship training programs under the allied health professional training provisions.

New section, page 72, "Authorization for the Capital Infrastructure Loan Program." This provision would establish a loan program that could be used to help rural health facilities improve their infrastructure and update technology. It authorizes $5 million in loans for these purposes.

New section, page 72, "Medicare Complex Clinical Care Management Payment Demonstration." Under this section, the Secretary is required to establish a three-year demonstration program in six sites to promote continuity of care, stabilize chronic medical conditions, and reduce poor health outcomes.

On page 10, new section, page 72. "Cost-effective and Quality Chronic Care Coordination for Medicare

Beneficiaries in Traditional Medicare." This provision would require the Secretary to develop a demonstration program to provide care coordination services in the traditional fee-for-service program for Medicare beneficiaries with multiple chronic conditions.

Senator Baucus. This is the provision that Senator Lincoln proposed?

Dr. Fowler. This provision I just read is an amendment offered by Senator Conrad. The previous demonstration was an amendment offered by Senator Lincoln.

Senator Baucus. Thank you.

Senator Conrad. If I could just say thank you to the Chairman and Ranking Member. I think this is an area where we can actually dramatically improve health care outcomes and save substantial amounts of money by focusing on that small number of people that use most of the budget.

Senator Lincoln. I would like to ditto that thanks.

The Chairman. Thank you.

Dr. Fowler. The bottom of page 10, new section added to page 72 of the mark, "Indian Contract Health Services and Medicare Payments." This provision would prohibit Medicare providers from charging more than Medicare rates for inpatient hospital services provided

to Indians who are eligible for contract health services from the IHS, tribally operated health programs, and urban Indian organizations.

New section added on page 72, "Tri-Care Access Improvement Provision." This provision would waive the late enrollment penalty for military retirees and spouses who sign up for Medicare Part B between January 2001 and December 31, 2004. The provision would also permit year-round enrollment through 2004 so that retirees can access the new benefits immediately.

New section added, page 72 of the mark, "Medicare Coverage of Routine Costs Associated with Certain Clinical Trials." This provision directs CMS to cover routine costs of clinical trials for medical technologies.

New section added, page 72, "Equitable Funding Adjustments for Home Health." This provision ensures that for two years home health agencies are limited in the reduction and the wage index portion of their payments to 3 percent.

There is a new addition also on page 72, "Adult Daycare Services Demonstration Project for Home Health Beneficiaries." This demonstration project would give Medicare home health users the option to receive some or all of current Medicare home health benefits in an adult

day care group setting.

New section, page 79, "State Carrier Medical Directors in Every State." This provision would require Medicare carriers to maintain utilization of at least one full-time physician carrier medical director in each State or reasonable geographic area.

Title VI of the mark, "Other Provisions," Section 601 would continue the BIPA rule for determination of Medicaid DSH allotments for half of fiscal year 2004, the last two quarters, and for the first two quarters of 2005.

New section, page 90, "Reimbursement to Health Providers for Uncompensated Care." This provision would help States and health providers defray the costs associated with providing federally mandated, but uncompensated, emergency medical treatment to undocumented aliens. This provision includes additional funds over four years to offset these unreimbursed expenditures.

The Chairman. On that point, Senator Kyl is chairing a subcommittee at this point at Judiciary, so he may have a question or clarification he wants to make about that particular point. It does not keep us from moving forward, though.

Dr. Fowler. On the last page of the modification,

new section, page 90, "Public Safety Net Hospitals' Purchase of Inpatient Drugs Exempted From Medicaid Best Price Calculation."

This provision would amend Section 1927(c)(1)(c) of the Social Security Act to exempt public safety net hospitals' purchase of inpatient drugs from the Medicaid best price calculations, the so-called 340(b) provision.

Senator Conrad. Could we just ask, what is the rationale for this?

Dr. Fowler. I believe that they are exempt on the outpatient side and this would exempt them from the inpatient side. I believe it is described as a technical correction, that they were intended to be included in that category and were not.

The Chairman. Are you satisfied with that?

Senator Conrad. Yes.

The Chairman. He is satisfied, so go ahead.

Dr. Fowler. New section, page 90, "Immigrant Children's Health Improvement Program." This provision would give States the option to provide Medicaid and State Child Health Insurance program coverage to lawfully present legal immigrant children and pregnant women for fiscal years 2005, 2006, and 2007.

Senator Nickles. Before you move on, how much is that new section on page 90, immigrant children, and also

pregnant women?

Dr. Fowler. I believe it is $350 million for that three-year period. We don't have official scores, but those are based on last year's.

Senator Nickles. Now, correct me if I am wrong, Mr. Chairman, but also as part of this bill we had, what, $1.6 billion of S-CHIP money that was carried over and not utilized? Is that correct?

The Chairman. I thought it was less than that. It was several hundred. Are you here to answer that? Let us ask you to answer that.

Ms. Kegler. It is actually $2.7 billion that has reverted back, or will revert back.

Senator Nickles. It would revert back and we have allowed it to be used.

Ms. Kegler. Right.

Senator Nickles. The States had not used it.

Ms. Kegler. Right.

Senator Nickles. But now we are talking about expanding S-CHIP.

Ms. Kegler. Right. And that provision, we are going to look at in a mark-up immediately following this. But, yes, this is an expansion to the S-CHIP program.

Senator Nickles. Now, this expansion of S-CHIP would include legal immigrant children? Right now, they

are not included?

Ms. Kegler. Yes, that is correct. It would be a State option.

Senator Nickles. We are including a bill, I am assuming. An eligibility or entitlement expansion. I am just trying to figure out what we are doing and what we are getting started here. So we are expanding S-CHIP. And correct me if I am wrong, but S-CHIP has more generous subsidies than even Medicaid.

Ms. Kegler. Yes, that is correct.

Senator Nickles. How much more? Some of this is coming back to me, but slowly.

Ms. Kegler. It is a 30 percent increase. For instance, if a State were to have a 50 percent FMAP for their Medicaid programs, they would have a 65 percent match for their S-CHIP program. The increase is 30 percent. It is a percent increase of 30 percent.

Senator Nickles. Mr. Chairman, I have raised this before and I do not think anybody is listening. S-CHIP has greater subsidies for higher income levels than Medicaid.

What we are doing now--correct me if I am wrong--is we are saying we are going to give legal immigrant children, and I guess pregnant mothers, a greater federal subsidy than we do Medicaid, the lowest-income persons,

who are also eligible for Medicaid for delivery, I am assuming, and I am guessing post-delivery, and I am guessing health care for the child. That is absurd.

We have done that in the past to encourage the government to insure, or help take care of, people in certain classes. But it is absurd to be having greater subsidies for higher income people than we do for lower income people, and now saying non-citizens. Is that correct?

Ms. Kegler. Yes. I believe, though, the option is to provide Medicaid and S-CHIP, so it would also expand the Medicaid program as well. So, it would expand that eligibility option to both programs. But your concern is correct, too.

Senator Nickles. For the life of me, and I do not know if the administration has looked at this, I do not know if others have. I see it is included in the Chairman's mark.

Usually that means it is not too controversial. I am not going to fight every fight on this bill. I am going to fight a few fights on this bill, and most of them are going to be bigger than this one. But I am concerned about it.

States did not use all their S-CHIP money, no matter how much the Federal Government was encouraging them, for

the last several years. Now we are telling they can use it without losing it. That is, what, $3 billion? I thought it was $3.8 billion.

Ms. Kegler. I think that is what the cost is, because there is some savings as well. I do not have those numbers in front of me right now.

Senator Nickles. My staff tells me it is $1.8 billion.

Ms. Kegler. Yes, that is correct.

Senator Nickles. And I believe in the budget we put in $1.8 billion, basically a fund that could be utilized.

Ms. Kegler. Right.

Senator Nickles. So we are giving the States a lot of money on different things. The amendment earlier that we alluded to, I think it was $3.5 billion on the dual eligibles.

I am not objecting to that, I am just trying to learn where we are spending money. We are spending money here where I think we are making a mistake. I want to at least voice some strong reservations.

I do not know if Mr. Scully or the administration has even looked at this.

Senator Baucus. Maybe Dr. Fowler could explain. Are there other points here that should be considered that we are not yet discussing on this one?

Dr. Fowler. This coverage was provided prior to the passage of the Welfare Reform bill in 1996, and this coverage was cut for these populations. This is a restoration of coverage that was previously provided.

Senator Baucus. It was cut in the Welfare Reform bill?

Senator Santorum. That was just on the Medicaid side, though.

Dr. Fowler. Oh, I am sorry. Just on Medicaid. You are right. S-CHIP was not part of the program back then.

Another factor, is that some States are providing such coverage right now at 100 percent State cost, so this would allow them to claim some federal help for those payments or that coverage.

The Chairman. I think what we will do, if there is discussion of this, we only have three minutes left to go vote. So I think I had better call a recess and go vote, and then we will come back.

Go ahead.

Dr. Fowler. There is one more provision. Should I finish the modification?

The Chairman. Well, the only thing is, other members want to discuss this provision, so I think I should give them the opportunity to do that. So, we will take a 10-minute recess.

[Whereupon, at 11:28 a.m. the meeting was recessed.]

AFTERNOON SESSION

[12:00 p.m.]

The Chairman. Here is what Senator Baucus and I have agreed to. Since there were people going to ask questions when we left, and those members are not back yet, I want to go off the modification, go onto the mark, because Senator Rockefeller has several questions he wants to ask of CBO at this point. We would take this time waiting for the other members to come back for Senator Rockefeller.

So, the Chair recognizes Senator Rockefeller.

Senator Rockefeller. Thank you, Mr. Chairman.

To expedite the process, I gave a copy of all of my questions to CBO so that we should be able to move through this. These are for the record and they will help me.

What is the average national premium and the possible range, high to low, that premiums could vary under this document? Is it possible that beneficiaries in private plans in California could be paying $85 a month, but beneficiaries in Florida are paying $35 a month?

Mr. Holtz-Eakin. We estimate that the average premium will be $35, but we do not make an estimate of the range of premiums or specific States in any circumstances.

Senator Rockefeller. The word "average" is a bad word because it does not tell you anything. So, in other words, do you have an instinct whether California, Florida, or West Virginia will differ?

Mr. Holtz-Eakin. We do not have an estimate of that.

The Chairman. Senator Rockefeller, let me interrupt here just a minute. I would like to have Mr. Scully listen to these answers, because I know that traditionally, the months we have been working through this, we have had some differences of opinion between CBO and CMS. If there is anything you should comment on, I do not know what it should be, I think I want the committee to know all the variations.

So, proceed, Senator.

Senator Rockefeller. All right. The second question, is the number and percent of Medicare beneficiaries who will fall into the coverage gap and reach the out-of-pocket limit.

Mr. Holtz-Eakin. That is a number we do not have available, as doing part of the cost estimate, much like the national average, you do not need that to get the total cost. It is an interesting part of the policy, but we do not have that.

Senator Baucus. Mr. Scully?

Mr. Scully. I know I have it in here somewhere, Senator. I saw it this morning.

Senator Rockefeller. These are kind of fundamental questions, it would seem to me.

Mr. Holtz-Eakin. These are certainly questions that are knowable, but given the time constraints for getting the overall estimate out, we did those things necessary for a cost estimate first.

Mr. Scully. Senator, the number of people that we think--and this is just our actuary's first cut in the last 24 hours--that would fall in the gap is about 4.7 million people and about 12 percent of the Medicare population that would actually spend enough money to go over the thresholds where they would actually fall in the donutter gap.

Senator Baucus. I cannot hear you.

Mr. Scully. Our actuary's back-of-the-envelope calculations from the last 24 hours--and I have to caveat that we have good actuaries--is that the people who would actually fall in the gap, whether they would spend enough to not hit the catastrophic threshold but get over the first level of threshold, is about 4.7 million people, about 12 percent of the population, obviously all above 160 percent of the poverty line.

Senator Rockefeller. And reaching the out-of-pocket

limit. Tom, do you have that?

Mr. Scully. The number to reach the----

Senator Rockefeller. Out-of-pocket limit.

Mr. Scully. I do not have that.

Senator Rockefeller. CBO does not have that?

Mr. Holtz-Eakin. Not yet. Not at this time.

Senator Rockefeller. All right.

Next, is the actual dollars in the plan that are spent on, number one, the drug benefit itself, provider add-backs, and that is all I need. I do not need the third one I have written down.

Mr. Holtz-Eakin. These are figures that were in the table we distributed to the committee. Since this table was put together, there were some modest modifications to the drug benefit, in particular, putting the cap at $4,500 instead of $4,725. That changes the estimate on the drug benefit from $408 to $402 billion over 10 years.

Senator Rockefeller. $402 billion?

Mr. Holtz-Eakin. $402 billion. It is $6 billion lower. And the provider add-backs are listed on pages 1 and 2 of the estimate.

Senator Rockefeller. Could you give them to me?

Mr. Holtz-Eakin. There is a long list of them. Simply adding them up is not that easy because they interact in many ways. There is a whole list there.

Senator Rockefeller. I will refer to that.

The next one, is percent of employers who drop retiree coverage and the number and percent of beneficiaries who will lose retiree coverage under this plan so far.

Mr. Holtz-Eakin. We do not have an estimate for the number of employers, but among employees who have employer-sponsored insurance, our estimate is consistent with 37 percent having their coverage dropped. That is 37 percent of those who have such coverage, about 11 percent of beneficiaries overall.

Senator Baucus. I did not hear you. You might pull the microphone up a little closer to you, please. Thank you.

Mr. Holtz-Eakin. It is 37 percent of those employees who have employer-sponsored coverage; it is 11 percent of beneficiaries overall.

Senator Nickles. And what percent would drop it?

Mr. Holtz-Eakin. We do not know the number of employers who would drop coverage. We know the number of employees who are affected.

Senator Nickles. Excuse me. This is Senator Rockefeller's time.

Mr. Holtz-Eakin. Let me repeat it so it is clear.

Senator Nickles. Just repeat what you said.

Mr. Holtz-Eakin. Underlying our estimates is that 37 percent of beneficiaries who have employer-sponsored insurance, retirees who have such employer-sponsored coverage, 37 percent will lose their coverage, and that is 11 percent of total beneficiaries.

The Chairman. Could I also add into this, Senator Rockefeller? What we also need to know, is what percentage of the figure you said might drop would potentially be dropped even if we were not considering this legislation? Because you make it sound like no employers are thinking about dropping that sort of coverage, and that they might be dropping it because we passed this bill.

Mr. Holtz-Eakin. Our assumption is that, in the absence of legislation, there will be no change. We are trying to find just the impact of the legislation.

The Chairman. All right. Thank you.

Senator Rockefeller. I only have four more quick questions.

The dollars spent by government under this program on PPOs to encourage them to serve Medicare beneficiaries, even though that has been reduced and I understand that. The inducement.

Mr. Holtz-Eakin. The total cost of the PPO provisions is in the table. It is $13 billion over 10

years. That has all the Medicare Advantage. It is the HMOs and the PPOs combined.

Senator Rockefeller. No, it is the PPOs that I am interested in. I am not interested in the combined figure.

Mr. Holtz-Eakin. We do not have a break-out of HMOs and PPOs separately at this point. They are very similar in the cost estimate, and in the interest of getting it done we provided the aggregate estimate.

Senator Baucus. I am confused here. There was originally a 2 percent addition, which was now dropped. That was for PPOs. I am just curious what the net effect of dropping that 2 percent is with respect to additional costs to the PPOs. It just seems like it would be a lot lower, if not zero.

Can anybody shed some light on this to help us on that? Dr. Fowler, do you have a point?

Dr. Fowler. Well, although we dropped the 2 percent, there are still provisions in there, for example, the floor calculations, the floor payments, are continued.

The current policy of floor payments is continued. So in those circumstances, and I think we will get into this when we talk about the PPOs, the bidding, and the benchmarks, but the benchmark for payment to plans is

based on the higher of current Medicare+Choice payments or fee-for-service spending in that area, and in some cases current payments are higher than fee-for-service. Those are primarily the floor counties.

Senator Baucus. Can anybody give us a back-of-the-envelope estimate as to what that will result in, that is, choosing the higher of the 2 or 3? As I hear you, it is basically current law, except that the payments will be higher.

Dr. Fowler. Some areas are currently below fee-for-service. There is a range of, I believe, 80 percent to 140 percent of fee-for-service. For those areas below fee-for-service, they would be bumped up.

Senator Baucus. I understand. But does anybody have a back-of-the-envelope net?

Dr. Fowler. I think that is the $13 billion.

Senator Baucus. Mr. Holtz-Eakin?

Mr. Holtz-Eakin. I am not sure we have got exactly the piece you are interested in isolated, but in iterations between the previous version and the one that we estimated for this hearing, the cost came down by $6 billion as a result of changing the nature of the payments.

Senator Rockefeller. All right. I want my question answered. It does not have to be now, and obviously

cannot be now. So far, nothing really has been answered. But do you understand why I am asking the question?

Mr. Holtz-Eakin. Sure.

Senator Rockefeller. Therefore, I would like to get a response on that.

Mr. Holtz-Eakin. We will get back to you with that. We just do not have it at this time.

Senator Rockefeller. Yes, but when, on all of these questions? I am not sure if you are going to answer my other questions either. When can you get back to me on all these?

Mr. Holtz-Eakin. It is going to be a matter of two things. Number one, separating out the HMOs versus PPOs is difficult in this particular specification because they are very, very similar, they face the same benchmarks and have a lot of very similar characteristics outside of their network structures and their geography.

So, dividing the estimate into those two pieces will be difficult and will take some time, and we also have other health-related legislation that is occupying us at this time, particularly the House. We will get it as fast as we can.

The Chairman. Senator Baucus, then Senator Breaux.

Senator Hatch. Could I make one comment on Senator Rockefeller, though?

The Chairman. We will come back.

Senator Hatch. Just on that point. The whole purpose of this coverage is to cover people who are not covered, right? That is one of the major purposes.

The Chairman. Yes. But also one of our goals was not to have people who have better coverage lose that coverage as a result of this legislation.

Senator Baucus?

Senator Baucus. I think Senator Rockefeller raises, generally, a very good point. Namely, we would like to know, and need to know, the answers to a lot of these questions because this is such important legislation. It is so complex.

I know you are working as hard as you possibly can, but even though you are, we still are just going to have to do whatever it takes to get these numbers. It is not just these questions asked by the Senator from West Virginia, but there will be others, too.

The Chairman and I have talked about this general problem. When the mark-up is complete, the three of us will have a discussion as to how we can get these numbers, and particularly for amendments that Senators have, so that we have the answers so we can respond intelligently, or at least with information--whether or not it is intelligent, at least with the information--as

we proceed. So it is a real fundamental question. As far as this Senator is concerned, I do not want us to proceed unless we have answers to a lot of these questions.

Senator Rockefeller. I have two more.

Mr. Holtz-Eakin. I am certainly sympathetic to the need for the information.

The Chairman. Senator Breaux had a comment he wanted to make on the point you were making.

Senator Breaux?

Senator Breaux. I have a question, if I could.

The Chairman. Oh, I am sorry.

Senator Rockefeller?

Senator Rockefeller. I would like to get the number and the percent of Medicaid beneficiaries excluded from the Medicare benefit.

Mr. Holtz-Eakin. This is about 15 percent. It is the dual eligibles.

Senator Rockefeller. The last one. Savings from assuming true, rather than total, out-of-pocket costs for stop-loss.

Mr. Holtz-Eakin. Again, we do not have that number. We did the cost estimate for this specification and not cost estimates for other possible specifications. So, in the interest of getting the costs of this particular bill

in front of you, we have done the one that was written into the language, but not others.

Senator Rockefeller. Mr. Chairman, can I request, along with Senator Baucus, that we do get this information?

The Chairman. First of all, Senator Baucus and I have thanked CBO by telephone for cooperation on getting us figures already. We appreciate that very much. But we do have this continuing problem, and we are going to sit down and see what we can do with the Director to make sure we get answers to the questions you have, and more importantly, we are going to have to get the scoring of amendments that will be offered on the floor. That is a major issue and we will just have to work our way through it.

Senator Rockefeller. I need to know that because what I do depends on some of that. I mean, it is very important for me to have that information.

The Chairman. And what I said would include your inquiries as well.

Senator Rockefeller. All right. Thank you.

The Chairman. Now I am going to go to Senator Breaux, but then just as soon as Senator Breaux is done, I promised Senator Daschle and others that we will go back then on our modification and get the modification

out of the way before we continue through the basic mark.

So, Senator Breaux and then Senator Daschle.

Senator Breaux. I just have a quick question now that we have Mr. Scully and Mr. Holtz-Eakin at the table, and that is with regard to the gap.

Do we have an estimate of how many seniors would fall within the gap which is now a gap of between coverage at $4,500, and I take it about $5,800? That gap exists, but there area a lot of seniors that would not reach that amount of drug coverage.

Second, a number of seniors would be low-income enough to get it covered by Medicaid. Third, a number of seniors would have coverage through that gap through employer or retirement plans, or whatever.

So there are a number of seniors. I would like to have no gap, but we do because of the money. So the question is, is there an estimate that is reasonable on how many seniors might fall within that gap based on all of the factors that they have in place?

Mr. Scully. Senator, I gave the first piece of that number to Senator Rockefeller a few minutes ago. This is another piece. So, I have got one answer to his question from my staff in the last few minutes.

There are 4.7 million seniors, our actuaries estimate, that would go over the first threshold and fall

into the gap or the donut; that is 12 percent of the population. Of those people, the number that continue on through and hit the now-adjusted catastrophic stop-loss is 7 percent, or 2.9 million people. Again, all those people are above 160 percent of the poverty level.

Senator Breaux. But does that take into consideration any of those seniors that are within that gap that would have coverage from their employer or retirement plans, for instance?

Mr. Scully. It should because it is a true out-of-pocket cost. We do not, at least in the bill, in my understanding from Linda and Liz, is that the true out-of-pocket cost does not count the employer contribution. So, our assumption would be that those people would not hit that because they have employer coverage.

Senator Breaux. And does CBO, Mr. Holtz-Eakin, agree with that estimate?

Mr. Holtz-Eakin. We do not have that estimate, as I mentioned to Senator Rockefeller. But we will get one to you and we will see how close they are.

Mr. Scully. We have not been able to calculate it in the exact rate of employer-estimated drop-out, people that will theoretically drop out of their existing coverage or employers dumping people. That number will probably be a little bit lower once it is calculated.

Senator Breaux. But the best estimate we have is about 12 percent, maybe a little lower, I am hearing you saying.

Mr. Scully. Twelve percent get into the gap and another 7 percent, 2.9 million people, actually hit the catastrophic limit.

Senator Breaux. All right. Thank you.

The Chairman. Now we will return to Dr. Fowler and Senator Daschle for questions on either the last one, or second-to-last one. We are almost done with the modification.

Senator Daschle?

Senator Daschle. Thank you, Mr. Chairman.

I guess I would just like a further clarification, if I could, from Tom on this issue of a gap. As I understand it, there could be retirees who get retiree coverage, and because they get retiree coverage, of that 4.7 million, do you have any idea how many will not ever get out of the coverage gap?

Mr. Scully. I do not believe that the calculation has been done, but I think most people that have retiree coverage, because the retiree contribution is counted, is not a true out-of-pocket cost, I think the answer is, virtually anybody that has retiree coverage would never hit the gap.

The Chairman. I should not interrupt you, but I just wanted to remind everybody that even if you are not in the covered group, you still get the benefit of the discounted drugs that have been negotiated as well.

Senator Daschle. That is right. But you are saying you would never get to the threshold where the gap began if you are a retiree?

Mr. Scully. Well, you could theoretically get to the threshold, I guess, of the gap, but you would never qualify for catastrophic because the catastrophic stop-loss is----

Senator Daschle. That is right. That is my point. Do you have any idea how many would be in that number?

Mr. Scully. I can find that out for you, Senator.

Senator Daschle. Could you? That would be great.

Mr. Scully. My guess is, it is probably a million.

Senator Daschle. The second question, Mr. Chairman, on Senator Rockefeller's question regarding the premium, I guess what I am wondering is how wide we expect the variation on the premium to be.

Obviously we are talking about a rough amount of $35 a month. I noticed with the Medicare+Choice plans, we have got a range anywhere from $16 in Florida for drug coverage under Medicare HMOs to $99 in Connecticut.

Do we have any upper estimate as to what the maximum

a senior might pay? If it is $99 in Connecticut, what would it be under the Medicare plan as we see it in the bill now?

Dr. Fowler. Well, the Medicare+Choice analogy is somewhat different from what we are talking about on drug plans because Medicare+Choice is not required to cover a standard benefit, or even an actuarial value. So, those benefits could be very different.

So, $16 could be very representative of different benefits than what somebody was paying at $99. For the purposes of this proposal, we did a couple of things to try to minimize some of that variation.

One of those is to adopt the FEHBP standard that would prohibit plans from charging premiums that were high and above what the cost of the benefit was.

The second thing we did was to adjust the premiums geographically for input prices. I guess there is one more thing. I am sorry. The third thing, is that the actuarial value provisions are fairly tightly constructed.

There will not necessarily be that much variation in the benefit, and therefore potentially not that much variation in the premium. But, like you said, there will be some.

Senator Baucus. If I might add here, Senator Daschle

has asked a very good question.

Dr. Fowler. That is right.

Senator Baucus. Well, we need to have an answer, if there is variation in the Medicare+Choice between $16 and $99. My understanding is there would not be nearly that fluctuation with the drug plans. But if that is the case, I would like somebody to tell me that that is the case. If that is not the case, we need to know that is not the case, and the reasons why.

Senator Daschle. And that is my point, and I appreciate Senator Baucus' interest in this as well. The reason I asked the earlier question about the consistency in the benefit, is that I am told that, even within the actuarial value requirements, there can be fluctuation, and that was acknowledged.

But then on the other side you have sort of three variables. You have the premium, you have the co-pay, then you have this retiree contribution and that will affect, of course, people's eligibility as well.

But leaving aside for a moment the retiree issue, you still have the co-pay and the premium variables on the other side to be able to reach the actuarial equivalent over here, but they could vary dramatically.

As it sounds to me, there is no upper limit written into the bill as to how wide a variation you could have.

Is that correct?

Dr. Fowler. That is right. On the premium, there is no upper limit on variation.

Senator Daschle. All right.

The Chairman. Mr. Scully?

Mr. Scully. We have lots of questions still about the freestanding drug benefit, but one of the other variables in the freestanding drug benefit is that our administrative costs for that are estimated to be about 20 percent for freestanding versus about 8 percent for PPOs.

So one of the many reasons we prefer the PPO model, is that we think the drug benefit for the same value of dollar subsidy will be significantly better.

Senator Daschle. Of course, using that model you could say that Medicare would only be 3 percent if you just offered it through Medicare. So, you could even get lower on the administrative costs if you wanted to go that far.

Mr. Scully. I will not get into that with you, Senator.

Senator Daschle. But, Mr. Chairman, as it relates to the S-CHIP question, Senator Nickles was asking some good questions about cost and noted the fact--and I think it was acknowledged--that the resources allocated for S-

CHIP had not been allocated. It is now in the process of redistribution.

But I think it is fair to say, and I would like somebody if they could, just to address that outstanding question, which was the reason I asked to be recognized. Because we are going through this phase-in, this implementation, and because the requirements vary, of course, from State to State depending on their own demographics, you had a slower-than-anticipated implementation of S-CHIP. But is it not also true that in the out years we expect a shortfall in S-CHIP resources right now?

Dr. Fowler. That is correct.

Senator Daschle. That is correct?

Dr. Fowler. Yes.

Senator Daschle. All right. Thank you. That was the only point I was going to make.

Senator Bunning. Mr. Chairman?

The Chairman. Mr. Hayes? Then I am going to call on Senator Bunning.

Mr. Hayes. The value of all of the standard benefits in the plans across the country are required to be equal and the government contribution for each beneficiary's premium is also equal, except that those contributions are adjusted for any differences in the

price of pharmaceuticals from region to region to minimize the variation that you are talking about.

Senator Daschle. But, again, the benefit is variable, but roughly equal if we hold it to an actuarial standard. The government commitment is equal. But that does not mean the individual commitment is equal.

The individual requirement for either premium or co-pay can vary significantly, as I understand it, because there is not any constraint right now on that those premiums or co-pays would ultimately be, in part because the government contribution is equal. Is that not correct?

Mr. Hayes. The proposal contemplates the plans competing in order to provide the best benefit for the best price.

Senator Daschle. Correct.

Mr. Hayes. And so that is, I think, the basis for the proposal.

Senator Bunning. Mr. Chairman?

The Chairman. Senator Bunning?

Senator Bunning. I want to ask Tom a question. It is my understanding that in going about getting bids in the 10 different regions, there obviously could be a different level of charges for those different benefits.

But how many individual States are going to be taken

care of under one PPO in the way that you have looked at these 10 different regions? In other words, Connecticut will not be by itself, or Florida will not be by itself.

Wyoming might. I say that, only because they have difficulty getting coverage and they have a way to do it. But is there not a grouping of States under the PPO and the Advantage area?

Mr. Scully. Yes, Senator, there is. I think it is left to the Secretary in the bill, but the assumption is that it would be the 10 existing CMS regions, which generally do not cut across major metropolitan areas.

So, for example, Connecticut would be in with all of New England. You would have to bid on one plan. In our scheme--the Senate bill is a little different--the premiums across the country were identical. I do not think the Senate bill would make them different in each of the 10 regions.

Senator Bunning. And do they not have to offer the same benefits that are being offered under Medicare Part B in addition to the drug benefit?

Mr. Scully. Yes.

Senator Bunning. Do the benefits not have to be the same?

Mr. Scully. Yes. And it also includes a catastrophic stop-loss for all costs.

Senator Bunning. All right.

What I am trying to say is, there is a consistency here that we are trying to arrive at by spreading our cost over a period of 10 different regions in the United States and arriving at the same benefit level that Medicare Part B has right now with the drug benefit added on. So, I am trying to understand what Senator Daschle was bringing up and trying to figure out why there is a problem with the differential for individual benefits.

As I see it, I mean, 99 percent of the people across the country--well, maybe that is an exaggeration. Ninety percent of the people across the country are going to have the same benefit whether the PPO is being charged slightly less or slightly more, but average-wise it is going to be the same benefit that Medicare Part B, plus the benefit for the drug coverage, that is being offered. Am I wrong?

Mr. Scully. I do not want to correct Senator Daschle's question, but I think the issue is that in each of the 10 regions there is also a separate bid for the drug-only plan as a supplemental add-on to the traditional benefit. The PPO is a bid for a comprehensive for Medicare supplemental and drugs.

Senator Bunning. Including all health care. I understand that. I just want to get to the drug benefit.

I am not going to talk about the improvements we are making in Medicare generally, because I think that is a very big plus to the bill. But I want to make sure that there is no misunderstanding about the drug benefit.

Mr. Scully. It is a similar structure for the drug benefit, a little more flexibility for the Secretary about the regions. But I believe it is assumed to be 10 regions where companies would come in and bid on the standard drug benefit.

Senator Bunning. At least three.

Mr. Scully. At least two, with a fall-back.

Senator Bunning. Two with a fall-back. All right. Thank you very much.

Senator Lincoln. Mr. Chairman?

The Chairman. Senator Lincoln?

Senator Lincoln. I just had a question in relation to what Senator Daschle was bringing up. Is it not correct that if the Secretary used utilization as another criteria along with the input cost and the other mechanisms that are in this bill, that it would give us a better ability to create a more standardized premium, particularly for some of our rural areas where utilization is high?

Dr. Fowler. I think that is an open issue. I think there are some that feel that adjusting for utilization

would smooth out some of the geographic variations and others who contend that there is not that much variation in utilization across regions.

Senator Lincoln. Is that the basis for their reasoning, is that there is not enough differential in the utilization that it would any difference, or do they just not think utilization is an important factor in determining this?

Dr. Fowler. I think it is that there might not be that much utilization. But I think there is not a lot of great data out there to make that determination.

Senator Lincoln. On utilization?

Dr. Fowler. Right.

Senator Baucus. I would just like to help things out a little bit here. I think a wrong impression is being left. Namely, I am extremely sympathetic to the point raised by Senator Daschle about variation, but there are a lot of provisions in this bill that address that which I do not think have been raised, and here is one right now.

One, theoretically, is that the premiums could be actually lower than $35 if competition works. That is, it could be lower than what is stated in the bill.

But second, and more important, there are provisions in the law today with respect to FEHBP that prevent plans

from price gouging members in the plan. There are strong standards in there, and these same standards that apply to FEHBP would also apply to the drug plans and apply to the PPOs that may participate. But it is a real problem and we are trying to address it.

In addition to that, as suggested here and as mentioned, there is a provision addressing geographic distribution with respect to costs and prices.

Now, the trouble is, we are trying to also do it for utilization. There is no data. I mean, for seniors, there are no drug plans that address the question of utilization.

Senator Lincoln. What is the problem with including it?

Senator Baucus. Because there is none.

Senator Lincoln. If it helps, good. If it does not, they do not use it.

Senator Baucus. That was what I was going to say. We are going to have to work on this when we get data. There is no data today, basically, on that point, on utilization for seniors. That is a real concern. It is a real problem.

Because we do not have the data, it does not exist, we cannot geographically adjust for utilization. We can somewhat for prices, but not yet for utilization. We

will deal with it as we proceed.

The Chairman. Senator Daschle?

Senator Daschle. I think the Senator is absolutely right with regard to the degree of data that is available. There is a Kaiser Family Foundation, and maybe this might be appropriate to put in the record at this point, Mr. Chairman, that goes through the per capital prescription utilization as of 2001. There is a significant variance.

Tennessee had 16.8 prescriptions per capita; South Dakota was 11.4. The United States as a whole was 10.9. So, there is about a 50 percent variation if this Kaiser Foundation evaluation of utilization is accurate.

But whether there is heavier or lighter utilization, from the point of view of the beneficiary, it would seem to me that that single senior out there in South Dakota, Montana, or anyplace else would want to know, just as they have with Part B. For Part B, we have a flat premium, $58, right now. Regardless of where you are, it does not vary. That is, I think, a question that we need to ask about this bill.

Do we want it to vary dramatically? Do we want to allow them to go down, as the bill certainly does? But is there a cap beyond which we would not allow them to go if we are going to provide the kind of continuity with

regard to premium coverage and cost that I think we want to accomplish here?

The Chairman. Mr. Scully?

Mr. Scully. Senator Daschle, I just want to point out that while we do not have the ability to vary on geographically specifically right now, we do have it on the basis of risk adjustment for age and for various co-morbidities and illnesses. As of last year, we have 61 different risk adjustment factors that we adjust our Medicare+Choice payments by, and we will adjust the PPO payments by.

Generally, I think the difference largely, for an Iowa or South Dakota, is based on older, sicker people using more drugs, and that would show up. If you used the existing risk adjustment, it would probably make up for a good piece of the geographic difference.

The Chairman. Before I call on Mrs. Snowe, I think we are on our basic underlying mark at this point for a walk-through. So I would like to cross the hurdle, so I am going to put this before the committee. If there are no further questions on the modification, then the modification will be adopted.

Senator Nickles. Mr. Chairman?

The Chairman. Senator Nickles?

Senator Nickles. Mr. Chairman, I think the S-CHIP

thing, which I do not believe was resolved, does not belong in this bill. That is a Medicaid expansion. It belongs on TANF. We can do a TANF bill. We are going to do a TANF bill. We must do a TANF bill. TANF, I believe, expires, what, the end of this month, so it has to be reauthorized. I hope that we do it clean, but we are going to do TANF this year.

To have an expansion that is rewriting the welfare bill, that changes immigration policy. When legal immigrants come to the country--correct me if I am wrong--they have to sign a waiver that they are not going to become a ward of the government for several years. Now we are saying five years, I believe.

For us to say that we are going to expand TANF or expand the CHIP program to cover this group of people, that distorts our immigration policy, it distorts the welfare bill that we need to debate, we need to discuss. It is not Medicare. It does not belong in this bill. It is a big expansion. It will be vigorously opposed, I would think, for a lot of reasons. It just does not belong here.

Now, we are going to do, and I have agreed to do, and we put in the budget, $1.8 billion releasing the unspent S-CHIP money. It was my understanding that we were going to pass that bill after we marked up this bill.

The Chairman. That is right.

Senator Nickles. And I am happy to do that. We put that in the budget at the request of Senator Snowe. The idea of that was to be a clean agreement, basically, releasing these funds that the States want, another one of our efforts to help out the States.

I understand that Senator Daschle said there may be more demand for S-CHIP in the future. Well, to expand S-CHIP, which has a great subsidy, and we are going to give a greater subsidy for non-citizens than we do for citizens, I just think there are a lot of mistakes by putting it in the bill at this time.

This is a Medicare bill. Let us wrestle with that when we do TANF or let us wrestle with it when we do S-CHIP, but it does not belong in this bill. So, I would urge you to delete that second-to-last amendment which we discussed prior to the break.

The Chairman. At this point, Senator Nickles, you obviously have the right to amend. But I also have the right to modify my amendment. I am taking that right to modify my amendment, and then appropriately we would have to consider your amendment down the road when we get on the amending process. So, my amendment is modified.

Now I would like to proceed to the underlying walk-through. Now, here is what I would like to do.

Senator Snowe. Mr. Chairman?

The Chairman. We have had this document before us since Tuesday at 10:00. I talked to Senator Baucus and we just had a lot of time taken, appropriately so, on a document that nobody had seen. The other one has been out there for a while. I would like to open this up to questions, but not have the line-by-line reading that we had.

Is there any objection to doing it that way? No limit on the number of questions anybody might want to ask, but just to proceed in a very disjointed way according to the questions that you have.

Now, I am going to have to call on Senator Snowe, then I will call on Senator Hatch, because Senator Hatch had been waiting on the underlying mark as well.

Senator Snowe?

Senator Snowe. Thank you, Mr. Chairman. I just wanted to follow up on the geographic adjuster. What are all of the factors that would be necessary to make that decision, and whether or not the Secretary would have the prerogative, as legislation is currently drafted, to make those adjustments? Or do they have to be delineated in the bill as passed?

Because I am contemplating, in working with Senator Lincoln, to give the Secretary the discretionary

authority to make that decision to make those types of adjustments to stabilize or equalize the premiums to the extent possible.

So if only the cost of drugs is included in the determination in the legislation as drafted, is it necessary to delineate the other factors or would it be preferable just to give the Secretary the discretion to be able to do it? Do you need that discretionary authority inserted in this legislation? Mr. Scully?

Mr. Scully. Speaking on behalf of the Secretary, I am sure he always prefers discretion.

Senator Snowe. But would it be necessary, as it is drawn?

Mr. Scully. It would clearly be very helpful.

Senator Snowe. Could he do it without the discretionary authority being vested?

Mr. Scully. I think, if that is what you want to do, to make sure we had the maximum discretion to make geographic adjustments, it would be very helpful to put that in the statute.

Senator Snowe. Well, it is because it is very specific in the legislation with respect to what is considered for that adjustment. In other words, only the cost of drugs is used to making that determination, not utilization or any other factors.

So is it necessary? I think that is an important issue here because we do have the same concerns about stabilizing and equalizing these premiums to the extent possible. If we have to delineate the factors and give the Secretary discretionary authority in order to do it, then obviously that is important.

Mr. Hayes. For the information of the committee, there are other factors that adjust the utilization and price variations between regions that apply in the bill that have not been discussed. Would it be helpful if I reviewed those as well?

Senator Snowe. Yes.

Mr. Hayes. In addition to having the standards that we have talked about and the ability to adjust the contribution between regions for variations in prices, there are also limits on the ability of plans to vary benefits. We have talked about that in terms of the FEHBP standard.

There is also a national definition of covered drugs. There are standards for the therapeutic categories and classes that are set nationally by the administrators so that those will be uniform across plans, so that will be another limitation on the ability of plans to game the system, if you will.

There is a risk adjustment system that is designed to

level out the amount of risk that plans undertake. There is also an 80 percent reinsurance payment for enrollees that experience very high costs above the catastrophic limit which will result in adjusting for those high utilizers between plans.

In addition, the Administrator is prohibited from approving any plan that violates any of the standards in the bill, including a plan that would be designed to select beneficiaries according to whether they are healthier or sicker. So, there are a number of other factors as well.

Senator Snowe. All right. So that is currently in this legislation, but in order to provide an expansive authority, then probably we should give the Secretary additional authority to be able to make that decision with respect to utilization.

Could the Secretary make an adjustment now, a geographic adjustment, on the basis of utilization as it is currently written?

Mr. Hayes. The Secretary or the Administrator will have access to data on utilization from the plans as the program is implemented, so that data would be available to the Administrator.

Senator Snowe. Thank you.

The Chairman. Senator Hatch?

Senator Lincoln. Mr. Chairman?

The Chairman. Let me get Senator Hatch, then I will get to you.

Senator Hatch. Mr. Hayes, let me ask you this question. Currently, Medicare covers therapies that are delivered in the physician's office setting, but does not cover therapies that are delivered in the home.

Now, people with multiple sclerosis are concerned about this approach because Medicare covers only one of the four injectable drugs or therapies. It is my understanding that the new--and correct me if I am wrong--Medicare Part D program, the stand-alone drug benefit, and in the Medicare Advantage programs, drug plans and PPOs, will have more flexibility than they would have the ability covering these other injectable therapies.

Now, am I correct that it could provide improved coverage for patients who need those for different types of therapies?

Mr. Hayes. That is correct. The drugs that you are referring to that are not currently covered or would not be covered under Part B of Medicare would be covered under the Part D drug benefit offered by the stand-alone plans or the Medicare Advantage plans.

Senator Hatch. And that would give more flexibility and improve the ability to get these therapies to the

people?

Mr. Hayes. Yes, sir.

Senator Hatch. Thank you, Mr. Chairman.

Senator Lincoln. Mr. Chairman?

The Chairman. I will call on Senator Lincoln, then I will get you, Senator Graham.

Senator Lincoln. I am sorry. I just wanted to qualify what Mr. Hayes was telling Senator Snowe. You said that the Secretary would have available to him information, but you did not answer the question as to whether or not he could use that as criteria in making a judgment on a premium difference, a standardized premium.

Mr. Hayes. Well, I would want to defer, perhaps, to Mr. Scully about that question in terms of the capabilities of the administration or CMS to be able to use that data for such an adjustment.

I was merely just trying to clarify for the Senator that that data on utilization, for the purposes of the reinsurance payments and risk quarter payments in the proposal, are reported by the plans to the Administrator.

Senator Lincoln. Right. But in terms of the premium, our interest there is to whether or not he can use that as criteria in determining what the premium needs to be.

Mr. Scully. I certainly think it would be clear, if

it was included that we did have that discretion, the Secretary had that discretion, then I would just point out that one of the frustrations that Chairman Grassley and others had earlier, is we do not, in using any of our traditional Medicare calculations, utilization results in much less per capita spending in certain parts of the country, particularly rural States. We cannot use that right now.

Certainly plenty of people, including Dr. Wendberg and others, have made the point we should. I think on the drug side, it would probably be helpful at least to have the Secretary have that discretion. Whether we use it or not, at least it will be an option. Right now, it is not.

Senator Snowe. Mr. Chairman?

Senator Conrad. Mr. Chairman?

The Chairman. On the same point? Because I was going to call on Senator Graham.

Senator Conrad. It is just a procedural question. We have really not completed a walk-through of the mark. Is that correct?

The Chairman. We have.

Senator Conrad. Of the adds to the mark?

The Chairman. Yes. It was just adopted, yes. But if you have a question on it, I will be glad to go back

to questions.

Senator Conrad. No. I would prefer to withhold until we get into the questioning. Maybe the Chairman could just inform members, how does he intend to handle the questioning of the underlying mark of CBO?

The Chairman. All right. Let me explain. This is what Senator Baucus and I ask. We are not dictating this, but we would like to not go through it line by line and just have you join in on any questions you want to ask. There will be no limit on questions.

Senator Conrad. Fair enough.

The Chairman. Senator Graham?

Senator Graham. I am going to move to a different subject.

The Chairman. Yes.

Senator Snowe. Mr. Chairman? I just wanted to follow up.

The Chairman. I did not see you.

Senator Snowe. I just wanted to follow up on the geographic adjustment. Otherwise, I will wait. It does not matter.

The Chairman. No, please go ahead now. It would be more appropriate.

Senator Snowe. All right. Mr. Chairman, I just want to clarify this issue. Would it be more certain or

add certainty to this issue in terms of equalizing the premium to give the Secretary the discretion to have expansive authority with respect to the criteria used to determine the premium?

If we are trying to get at equalizing the premium in some way, other than short of saying $35 in this legislation, is there another way of saying that the Secretary will have the discretionary authority to do it? Is that the other way to attempt to achieve that or accomplish that over time, with minimal difference?

Mr. Scully. I am looking at Liz, who may not agree with me. But my experience, having gone through the physician payment update last year where we were tied in by the SGR and other things, if the Secretary has the discretion to use that without a mandate to use it, it certainly makes our options easier if the goal of the committee and the Senate is to make sure that the premiums are as uniform as is practical.

Senator Lincoln. But regardless of the information, you are not bound to use it, correct? That is what you are saying.

Senator Snowe. That is right.

Senator Daschle. Mr. Chairman, on that point.

The Chairman. Yes. Then we will go to Senator Graham.

Senator Daschle. We know what the national average is going to be, do we not? The national standard is written into the bill. We define it. It is a calculated figure, is it not?

Mr. Hayes. There is a uniform federal contribution for all of the drug coverage plans in both the stand-alone plans and in Medicare Advantage, along with the adjustments that I have mentioned.

Senator Daschle. So what would the national average be calculated to be right now?

Mr. Hayes. According to CBO, that national average would be $35 a month.

Senator Daschle. So one other way to do it--and I am contemplating an amendment at the appropriate time. I do not know that I will offer it--is you could say that, while it could go below the national average, it could not go any more than 5 percent above the national average.

I mean, that is basically what we do with the Medicare Part B. We have a flat, across-the-board, $58 now that varies according to overall costs and that are passed on to the beneficiary. But that is one possible way, answering the Senator from Maine's question.

The Chairman. Senator Graham?

Senator Graham. This is a different subject.

The Chairman. Yes. Proceed.

Senator Graham. To anyone on the panel, what is the assumption under these numbers as to what percentage of the Medicare eligibles will voluntarily elect to go into Part D?

Mr. Blum. I think, according to CBO, their estimate is that 78 percent of beneficiaries will join the Part D drug benefit, roughly, but that virtually all Medicare beneficiaries will have coverage for drug benefits. But 78 percent will join the Part D benefit.

Senator Graham. I have two different numbers here as to what the break-even point is. One number is $1,115, and another is $1,290. What is your calculation of when a participant will have returned to them in the discounted drug cost what they have paid in the $35 per month premium and the $275 initial deduction?

Mr. Blum. Senator, for beneficiaries that do not have secondary coverage but do not cover for the low-income protections, our staff estimates the break-even point is about $1,200, roughly. Beneficiaries that qualify for the low-income protections will fare better, but those beneficiaries that do not qualify will be about $1,200.

Senator Graham. Well, at that number, approximately, and I am looking at a CBO chart of the

percentage distribution of enrollees and dollars per amount spent on outpatient prescription drugs, there would be somewhere between 35 and 40 percent of the estimated 2006 beneficiaries who would fall under $1,200 in terms of their prescription drug costs.

Mr. Blum. We have not calculated that number, but that sounds about right. The point would be also that that is true for the Medicare Part B benefit as well, that some beneficiaries do not always hit the amount of money that they pay in Part B premiums that they receive in Part B services.

Senator Graham. I think the reason they do that, is they make a calculation that even though I will not receive, at my current level of expenditures, what it is going to cost me to participate in Part B, I see Part B as an insurance policy. That is, if I fall into very high outpatient costs, I will have that covered.

If that is the motivation for people who are currently not spending enough to come within the $1,200, it seems to me that the inducement is the catastrophic provision, that they want to buy into this even though it is not cost-effective in the specific year because they might have some event in their lives that would suddenly put them up into the catastrophic level.

Do you agree that that is the primary motivation of

people who are less than $1,200 to participate?

Mr. Blum. One of the reasons that people join the Part B benefit is because they would pay a penalty for signing up for the benefit late. So if you do not join the Part B program when you first turn 65, you are a senior that qualifies for Medicare, then you would pay a penalty.

That same penalty would also apply to the Part D drug benefit to encourage seniors and Medicare beneficiaries to join early. But I think that one of the more beneficial things about this drug benefit in the Chairman's mark is the catastrophic benefit for Part D drugs.

Senator Graham. Last year when we were talking about similar legislation, we had the catastrophic in the vicinity of $4,000, and the assumption was that we would have better than 90 percent participation at that level. We now have raised the catastrophic level to, what, $5,900? What is the catastrophic level now?

Ms. Fishman. $5,813.

Senator Graham. All right. Fine.

Have you calculated whether that catastrophic that kicks in at $5,813 is going to be sufficient inducement to get a substantial number of these people who currently will not benefit by participation to do so?

Mr. Blum. Yes, Senator. According to CBO's estimates that they made based upon the Chairman's mark, CBO currently estimates that less than one percent of Medicare beneficiaries will not sign up for the drug benefit. About 99.5 percent of beneficiaries will be in this Part D drug benefit, not counting the dual eligible population.

Senator Graham. That is counter-intuitive. If you have got 35 to 40 percent of the people who, on a straight evaluation of their current drug costs--this is for the year 2006--will pay more in than the benefits that they will get out, and if, in order to qualify for the catastrophic they have got to spend $5,813 or more, it surprises me that you think that such a high percentage will enroll.

Mr. Blum. I think that the numbers are based upon CBO's estimates that we received from them. They seem confident that there will be a strong take-up rate in the benefit.

Senator Graham. Is there somebody here from CBO who can answer?

Senator Baucus. Right there, yes.

Mr. Holtz-Eakin. There are two features that have not come up yet that would induce seniors to pick up the benefit. Number one, there is a one-time election, so

individuals will not be in the position that you might suggest where they have a very good estimate of their current-year drug spending and make a year-by-year decision on whether to participate, but they will have to, early on, make a decision over a long span.

The second, is that as an insurance package, this has a 70 percent subsidy so it is a heavily subsidized insurance policy and many will purchase it.

Mr. Scully. I would note, Senator, our actuaries agreed. We have different agreements on the PPO update rate, but on the freestanding drug package, we basically agree.

Senator Graham. Thank you.

The Chairman. Before I call on Senator Conrad and then Senator Bingaman on the floor, I just wondered, how many more people have questions to ask so I know how soon it will be before we get to amendments?

[A showing of hands].

The Chairman. All right. Senator Lincoln and Senator Nickles, and Senator Graham again. All right.

Senator Conrad?

Senator Conrad. Thank you. So the take-up rate that you are predicting here is over 99 percent?

Mr. Holtz-Eakin. Will have coverage, yes.

Senator Conrad. Mr. Holtz-Eakin, you indicated

there is a penalty for a failure to sign up when it is initially offered.

Can you tell us what kind of a penalty somebody might face as a result of this legislation if they do not join when it is immediately available?

Mr. Holtz-Eakin. The penalty is an actuarially appropriate increase in the cost of the policy for deferring entry into the program.

Senator Conrad. What does that mean in dollar terms?

Mr. Scully. We did that in Alpha Part B. I think it is left to the Secretary's discretion, but we do it now essentially in Part B. The problem is, if this healthy 65-year-old goes into the program and chooses not to sign up, and they wait until they are 72 and sick to sign up for the drug benefits, it basically throws off the entire insurance pool and then you are taking healthy people out of the pool.

So if you do not effectively penalize someone for doing that and say if you wait to join until you are 72 you are going to pay more.

Senator Conrad. I understand the rationale. My question is, what is the penalty?

Mr. Scully. It depends on the year, how long you wait, and how long you get in. The Secretary, in Part B,

basically set various adjustments, and you would have probably have anywhere from a 10 to 50 percent higher rate, depending on how long you waited.

Senator Conrad. Ten to 50 percent higher rate.

Mr. Scully. Just depending on when you join.

Mr. Hayes. If I may add to that as well regarding the penalty.

Senator Conrad. Yes, sir.

Mr. Hayes. In addition, any beneficiary that has had creditable coverage that is as good as, or better, in value to the Part D standard benefit are not penalized for late enrollment while they have that plan.

So, for example, if you have someone who is in FEHBP and is receiving drug coverage as a retiree from FEHBP, if they decide to enroll later in Part D, they would not pay the late enrollment penalty.

Senator Conrad. Mr. Holtz-Eakin, when you say there is a 70 percent subsidy, as I understand it, that refers to the amount of the covered benefit. But what percentage of beneficiaries' drug costs for the period covered by this bill are covered by this benefit?

Mr. Holtz-Eakin. I do not have that estimate.

Senator Conrad. I am told that that is about 25 percent. Does that sound reasonable to you? Approximately 25 percent? The number we have been given

is 25.3 percent.

Senator Baucus. That sounds low.

Mr. Scully. I cannot give you a precise number, but I think it is closer to 40.

Senator Conrad. That is a big variance, 25 to 40 percent. I cannot see how it could be 40 percent.

Mr. Scully. Well, it depends on the population. For over 160 percent of the poverty where the subsidies are less, which is 44 percent of the people, is much, much, much higher. It is probably more like 80 percent. But above 160 percent of poverty, it is obviously a lower subsidy. So, it depends on where you are.

Senator Conrad. Well, let us see if we can get an answer to that question. I mean, that is the kind of thing I think we have got an obligation to try to answer as we go through this.

Mr. Holtz-Eakin. Senator, there is a total benefit of about $550 billion out of a baseline estimate of $1.6 trillion in prescription drug spending by this population. The issue becomes how you treat the low-income subsidies and the premiums in calculating the fraction of the subsidy.

Senator Conrad. So that would be something over 30 percent.

Senator Baucus. I have some numbers here that I

think will help. I hope they help. Basically, what I have here is a Drug Benefit Summary chart. For those seniors 74 to 100 percent of poverty, they say $4,900, roughly, which is a 98 percent reduction in their out-of-pocket costs.

The next category of those are 100 percent to 135 percent of poverty. Those seniors save close to $5,000, which is a 96 percent reduction in out-of-pocket.

Senator Conrad. Are those savings over the years of the bill, the $5,000? That is not a yearly amount.

Senator Baucus. In the course of a year.

Senator Lincoln. What was the first category you listed?

Senator Baucus. The first category is what we call QMBs, 74 percent to 100 percent of poverty. Then the third category is 135 to 160 percent of poverty, and the senior saves $4,200, which is an 84 percent reduction in out-of-pocket costs.

Senator Conrad. How can that be? How can they be saving $5,000 or $4,000, when the vast majority of people would have less drug costs than that a year?

Senator Baucus. Well, we give significant subsidies and benefits to low-income people.

Senator Conrad. Absolutely. I think that is one of the strongest parts of the bill. But it seems improbable

to me that people are having drug costs that high in a year.

Senator Baucus. And then the final category is those who are above 160 percent of poverty, where a senior saves 46 percent, $2,300, roughly, which is a 40 percent reduction in out-of-pocket costs, and that does not include the catastrophic benefits that a person received who would be suffering from a catastrophic illness.

Senator Conrad. Maybe we could ask CBO if you could get us a number.

Mr. Holtz-Eakin. We will.

Senator Conrad. The third question I have, and I think you have mentioned this, the percentage of participants with employer-sponsored insurance that would have their employer coverage dropped. I recall you saying 37 percent.

Mr. Holtz-Eakin. Correct.

Senator Conrad. And what is the basis of your analysis that that percentage of people would have their employer-covered insurance dropped?

Mr. Holtz-Eakin. With the addition of a government-provided benefit, employers really have three options. They can do nothing, and in some cases they will have an interest to make no change to their coverage, if they have negotiated an arrangement with their union, for

example.

They could scale back their coverage somewhat and rely more on the Medicare prescription drugs, or they could drop it entirely. In those latter two cases, they can use the additional resources to provide other kinds of employee compensation.

What we have done, is examined the literature, to the extent we can find it, on employer responses to the shape of compensation packages in shaping our estimate of the number that will drop.

Senator Conrad. All right.

Let me go to something that I have found difficult to follow. I would like, if I could, to have the attention of the Chairman.

Senator Frist. Senator Conrad, just on the employers dropping it, can I ask a follow-up question, just real quickly?

Senator Conrad. Yes. Absolutely.

Senator Frist. You said it is 37 percent of employers that are going to drop?

Mr. Holtz-Eakin. Yes.

Senator Frist. This has huge implications.

Mr. Holtz-Eakin. It is 37 percent of employees, of retirees with such employee insurance.

Senator Frist. All right.

Mr. Holtz-Eakin. And that is 11 percent of overall Medicare beneficiaries.

Senator Frist. All right. If we did nothing, how many would be dropped over the next 10 years? If you look at these curves, the employers are getting out of the business anyway. Not out of business, but the curve is going down. What would it be 10 years from now?

Mr. Holtz-Eakin. We do not have an estimate of that. We isolated our estimate on the impact of the bill above the baseline. That is a question about the baseline estimate and I do not have that.

Senator Frist. All right.

Senator Conrad. It is 37 percent, just so we are clear with each other. As I understand it, this 37 percent is the effect of our legislation.

Senator Santorum. I think the question Senator Frist has, is in your baseline you have an assumption that there will be changes, though, correct? Or do you not?

Mr. Holtz-Eakin. No, we do not.

Senator Santorum. Would you suggest that that is an inaccurate baseline?

Senator Breaux. In reality it is.

Senator Santorum. Since reality is not that. I can have a few of my retirees in Pennsylvania give you a call

if you have any questions on that subject. I think that is unfair. Baselines are supposed to be real. They are not supposed to be artificial. That is artificial.

Mr. Holtz-Eakin. The baseline issue that is most important that we capture, is new retirees not having such coverage. This is a provision would that induce existing retirees who have such coverage to have their coverage dropped or modified by their employers.

Senator Santorum. I understand what this provision does. I just want an understanding of what would happen without this being calculated into the baseline.

Mr. Lieberman. Senator Santorum, we have looked at the literature and the surveys of the employee benefit consultants of retiree offerings. What we understand is mainly happening, is that for current workers who are newly hired, employers are no longer putting as part of their compensation package a guarantee of retiree health care.

As far as we can tell, the base of people who are near retirement or retired, there is not that much erosion going on.

Senator Santorum. I will have the people from Bethlehem Steel and seven other steel companies in Pennsylvania that I can think of off the top of my head give you a call and let you know that their retiree

health benefits have been eliminated. I mean, it is happening all over the place.

Senator Rockefeller, would you like to join in with this? I mean, I think you need to look at your baseline, please, then give us an understanding, maybe looking back over the last few years and projecting forward, given the trends, how the baseline would be affected. I think that would be a much fairer score as to what the impact of this bill would be.

Senator Conrad. Mr. Chairman?

The Chairman. Senator Conrad, continue.

Senator Conrad. Let me just say that I agree entirely with Senator Santorum. We know that employers are dropping their plans. I understand your answer to this question is the effect of this bill. I think one of the things we have got to do, Senator Frist said it well, this has got major implications, 37 percent having their health care plans dropped.

That means it is going from being on the company's nickel to being on our nickel. That dramatically increases the cost. So, if we can find ways to hold that number down, that is in our interest and we should pursue it.

Mr. Holtz-Eakin. If we could, before we leave this, just to clarify.

Senator Conrad. Yes, sir.

Mr. Holtz-Eakin. I understand the policy interest, and I am sympathetic to the importance of understanding the underlying issue. But in terms of scoring and what will show up in a cost estimate, it will just be the impact above this bill above or below the baseline.

Senator Conrad. Right.

Mr. Holtz-Eakin. And your concerns would not affect the score in the bill.

Senator Conrad. We understand that. It has got implications obviously for us in terms of looking at the specifics of this legislation, how it might be altered to hold down your score, and what actually happens in the real world.

Let me go further, if I can, because this is a matter that I think is very important for us to understand. That is, what are the fixed elements of the standard benefit? We have got a premium, we have got stop-loss, we have got co-insurance, we have got deductibles.

My staff has been told at various times that the deductible and the stop-loss would be fixed to prevent risk selection that could cost the government money and destabilize plans.

But when we look at this document, it would appear that none of those are fixed. I would ask CBO, if I

could have the Director's attention, is it true in your analysis that the deductible could be higher or lower than $275?

Mr. Holtz-Eakin. Our understanding is that you can modify from the standard benefit. Everyone has the option of providing an actuarialy fair alternative benefit. That may affect the pool of participants in any particular drug plan. It would not, however, because it is actuarially equivalent, affect the cost. Our cost estimate would not be affected by that.

Senator Conrad. Right. The cost estimate would not be. I am trying to look at this from the standpoint of a beneficiary and what they might face out there in terms of--we are saying this is a $35 premium, $275 deductible, 50 percent co-insurance. I am just trying to make certain that we understand and that the public understands that that can vary because companies can offer alternatives.

So, it could be a deductible that is more or less. It could be a premium level that is more or less. It could be a co-insurance level that is more or less. It could be a stop-loss level that is more or less. Is that not the case?

Mr. Holtz-Eakin. I want to clarify to make sure all the facts are right. My understanding is, in the most

recent specifications which have been moving this, stop-loss has been fixed so it cannot change, and the deductible may go down, but it may not go up.

Senator Conrad. Very good.

Mr. Holtz-Eakin. The other parameters may be varied.

Senator Conrad. So let us get that on the record very clearly, because we have had a moving target. So the stop-loss now is fixed. All right. So we are talking about $5,813.

Dr. Fowler. It is $3,700 in out-of-pocket.

Senator Conrad. In out-of-pocket, which translates into the $5,813 that Ms. Fishman mentioned.

Ms. Fishman. In total drug spending.

Senator Conrad. Total drug spending, $5,813.

Ms. Fishman. Yes.

Senator Conrad. In terms of the deductible, that could go down but not up. The premium could go either way, could go up or could go down. Is that right?

Mr. Holtz-Eakin. Yes.

Senator Conrad. The co-insurance level. That could go up or it could go down.

Dr. Fowler. Can I clarify also?

Senator Conrad. Yes.

Dr. Fowler. On the co-insurance level, in talking

about the actuarial value, it is a little bit more restricted than I think is made clear here. The subsidized portion of the benefit has to be actuarially equivalent to the subsidized portion of the standard benefit and the unsubsidized value has to be the same as well. So, there are certain restrictions that----

Senator Conrad. There are limitations on how much it can move, is the point that you are making.

Dr. Fowler. That is right.

Senator Conrad. Let me go to the next point, if I could.

The Chairman. Before you go to your second point, Senator Rockefeller wanted to follow up on your previous question.

Senator Conrad. Yes, sir.

Senator Rockefeller. Senator Conrad and Senator Santorum, I just wanted to say for the record, because I did not respond when you included me in your argument, if one goes to Bethlehem, Pennsylvania, where I was several weeks ago, you can drive five miles by empty steel mills. It is one of the most tragic sites that I have ever seen in my life.

But the point I wish to make, is the point that Senator Conrad made. You cannot say the world is working in certain ways, and therefore we can predict such and

such is going to happen. What we are concentrating on here is what this bill does, and only on what this bill does, not what might happen in the free enterprise, or otherwise, world. That is all I want to say.

Senator Lincoln. Mr. Chairman?

The Chairman. Senator Conrad?

Senator Conrad. If I could just go back to the break even point. Have you calculated the break even point? That is, at what point, what dollar amount that seniors will get more benefit than they paid for, what would that amount be?

Mr. Blum. For beneficiaries that do not qualify for the low-income assistance, that break even point is about $1,200. But those beneficiaries that do qualify for the low-income protections, that break even point is substantially lower. I do not have the figures.

Senator Conrad. Well, let us try to be clear about this. We do not want to mislead people as to what we are doing or what we are not doing here. We are limited in the amount of money that we have. That requires us to make certain restrictions on what is available.

What I hear you saying--correct me if I am wrong--is that the break even point is about $1,200. What do you mean by that?

Mr. Blum. For those beneficiaries that do not

qualify for the low-income protections at 160 percent of poverty and higher, those beneficiaries would have to spend, in their premiums per month, $35 on average, plus deductible, plus the co-insurance they would pay. By the time they would pay all those costs, they would break even in their out-of-pocket costs at about $1,200 of drug spending.

Senator Conrad. So if they had less than $1,200 a year of drug costs, this would actually be costing them money.

Mr. Blum. Correct. But that is similar to the way the Part B program works today, whereas some seniors that have Part B coverage, but pay the Part B premium, receive less health care services than they pay in premiums. This benefit has a 70 percent subsidy to encourage beneficiaries to join the Part D benefit.

Senator Santorum. If the Senator from North Dakota would yield for one moment.

Senator Conrad. I would.

Senator Santorum. I think the better answer of this is, that is the essence of insurance.

The Chairman. Praise the Lord, Senator Santorum! [Laughter].

Senator Santorum. I mean, obviously, if everyone used the amount, then there would not be insurance. The

idea is, some people are going to be below, some people are going to be above, and that is how insurance works. So, yes, this is an insurance program.

Senator Bunning. Except for Senator Rockefeller, everybody pays more into Medicare Part A than they use. I am kidding with you. [Laughter]. All of us are donating to Medicare Part A and we are not taking anything out of it, so we are subsidizing the ones that are using it.

Senator Conrad. I thank Senator Santorum. That was going to be my next point, is this is the nature of insurance. But these questions are being asked. We ought to make sure it is in the record exactly what this is and what it is not so it is clear to people.

When the future is written, people come back and say, gee, I did not think that was the way it was going to work. We ought to make clear that it is the way it is going to work, and there are reasons for it. It is the nature of insurance.

Let me go to the fall-back availability.

Senator Rockefeller. Which are also an unanswered questions that I asked of CBO and need to be answered, because the 37 percent kicked off quite a response.

Senator Conrad. Yes.

Fall-back availability. This is also, Mr. Chairman

and Senator Baucus, if I could, to me, an important question. On page 12 of the mark, it says the Administrator "shall determine each year whether there are two private plans in a region," but it does not say that the Administrator shall enter into a contract to ensure that a fall-back plan is available when there is no private plan.

Instead, it says the Administrator "would" enter into a contract. I am curious, why this difference in wording? What guarantee is there that a fall-back plan would actually be available? I think this is a critical point.

Dr. Fowler. The legislative language, which is in the process of being drafted, clarifies that the Administrator "shall" enter into a fall-back plan if two or more private plans are not available.

Senator Conrad. Excellent. Thank you very much. I think that is a very important point.

The Chairman. Are you done?

Senator Conrad. I have other questions, Mr. Chairman, but in the interest of others having time----

The Chairman. No, proceed right now. I think we are going to have to work our way through these questions and we might as well do it this way.

Senator Conrad. All right.

The indexing of Part B deductible to inflation. Prior to seeing the mark, I did not know that this provision would be part of it, that is, indexing the Part B deductible for inflation.

What is the estimate for what that deductible will be under this provision at the end of the 10-year scoring window, if CBO could tell us that? What is it now and what is your anticipation for what it would be, being indexed for inflation?

Mr. Holtz-Eakin. The provision is to raise it from $100 to $125 and then index for inflation, or to index it to the CPI for inflation.

Senator Conrad. So explain that to me. Slow down and make sure I understand.

Mr. Holtz-Eakin. A one-time increase from $100 to $125.

Senator Conrad. So there would be an immediate increase from $100 to $125 deductible.

Mr. Holtz-Eakin. That would happen in 2006.

Senator Conrad. In 2006. All right.

Mr. Holtz-Eakin. And thereafter, the deductible would rise with the Consumer Price Index.

Senator Conrad. And what would it be then at the end of 2013?

Mr. Holtz-Eakin. About $152.

Senator Breaux. $152. So the deductible is going from $100 today to $152. I think we should have that in the record, and that should be understood.

The Chairman. Senator Conrad, I think it is the desire of other members for me to come back to you.

Senator Conrad. Great.

The Chairman. I just want to make it clear that I do respond to suggestions from the committee.

Senator Bingaman?

Senator Bingaman. Thank you, Mr. Chairman. Let me make it clear, I was not the one who made the suggestion. I thought these were excellent questions.

The Chairman. You were not the one that made the suggestion.

Senator Bingaman. Yes. I was learning a great deal.

One of the things I noticed on Friday when we had the hearing, Tom, when you were testifying, is that it seems that there is a lot of uncertainty about how many people will choose, who are now just in Medicare, to sign up for one of these PPOs.

Let me just get that clear again so that I have got it in my head. Tom, what was your estimate of that?

Mr. Scully. Our current estimate is that, by 2008, I believe, that we would have----

The Chairman. Forty-three percent.

Mr. Scully. Forty-three percent in HMOs and PPOs. It is 15 percent in HMOs, and 28 percent in PPOs, and I believe CBO's estimate is zero for PPOs, or very close to it. It is a fundamental disagreement among our actuaries, and I have been through seven or eight fundamental differences or assumptions that I think are understandable.

Over the years, I'd say CBO and OMB's scoring on Medicare has been unbelievably consistent, within half a percent. But we are getting into new areas where the program does not exist, both in drug coverage and in PPOs, where we do not have any behavioral experience and their assumptions are different than ours, but I think they are honest disagreements. We believe that, under the current structure, a large number of people would choose PPOs. It varies by region.

Senator Bingaman. So your estimate is 43 percent will choose to go into PPOs or HMOs by 2008, and CBO says zero percent?

Mr. Holtz-Eakin. We would estimate that 9 percent of beneficiaries would be in either PPOs or HMOs, and the division between them is not terribly distinct under this language, but I guess it would be 1 percent or under in PPOs.

I want to echo the comments of Tom Scully. These are honest differences in trying to read a very uncertain future.

Senator Bingaman. Well, I appreciate those answers. Let me just say that one of the concerns I have, since there is so much uncertainty about how many people are going to leave traditional Medicare and go into one of these programs, one of the concerns I have got is, if Tom turns out to be right and there is a substantial number of people who shift over, even if there is a smaller number, what is the effect of that, both on disproportionate share hospitals, and what is the effect of that on community health centers?

I have a couple of amendments, Mr. Chairman, which, when we get to amendments, I will offer those. But essentially the point is that we now make a payment under Medicare to disproportionate share hospitals. It is an add-on when people come in to get service, as I understand it, and there could be a dramatic reduction in the amount of those DSH payments to disproportionate share hospitals.

There could also be a significant reduction in the funds going to community health centers if we have a lot of folks shifting over. I just wanted to raise that issue. If either Tom or Mr. Holtz-Eakin wanted to

comment on it, I am glad to hear their comment, but I am really just trying to make the point that we have got a lot of uncertainty.

The Chairman. He is trying to make a point. Let him make his point and let it go there.

Senator Baucus, did you want to follow up on that?

Senator Baucus. Well, yes. I think Senator Bingaman has asked a very good question here, and you two have explained that there is a difference between the actuaries at CMS and also at CBO, and that is obviously based on assumptions.

I would like to know, what are the one or two biggest assumptions? What are the two or three most significant assumptions where there is a variation? What are the assumptions? There must be one or two assumptions that kind of skew this thing one way or the other, and I think it would be helpful to all of us to know what they are so we can make a judgment of whether we agree with those assumptions or not to help answer the question indirectly raised by the Senator from New Mexico.

Mr. Holtz-Eakin. It will be interesting to see if Tom and I say it the same way, but I will go first and he is free to disagree.

Senator Baucus. Right.

Mr. Holtz-Eakin. I would say that the things that

we hold in common are that competition will serve to push prices, premiums, down to cost. Where we disagree, is what the underlying cost structure of a PPO will look like, especially relative to fee-for-service Medicare.

In our view, a system of PPOs that covers the entire Nation and the entire Medicare beneficiary population will, on average, cost more than Medicare fee-for-service, and as a result, will not be a cost saving in scoring these bills.

I would say the core difference is that Mr. Scully's actuaries would estimate that there would be some cost savings associated with that, and as a result we are on opposite sides of even the direction of that particular piece of this estimate.

Senator Baucus. Mr. Scully?

Mr. Scully. We have been having a friendly debate about this for two months. Once again, my actuaries, I think, have a long tradition of being independent and traditionally had a great relationship with CBO's. But our fundamental view is, it is pretty well defined that Medicare pays 10 to 12 percent less than private health plans for many services, because we can fix prices and we can fix them artificially low.

CBO has used that to say they believe, in many cases, PPOs may cost more. Our actuaries base it on the 34 PPO

demonstrations that we have had out there for a year and the prices that they gave us last year, as well as the experience with the Federal Employees Health Benefit Plan and Tri-Care, which are both similar in structure, and believe that PPOs do a much better job of managing utilization and looking at the overall patient situation.

They believe we are not going to save a lot of money. Their view is that it will cost, in the first year, about the same, even a little higher, because of administrative costs. By the third and fourth year, the costs are 1 to 2 percent lower permanently. CBO thinks they are probably 10 to 12 percent higher.

So, fundamentally, when you come in and offer a PPO that can beat, at 100 percent of fee-for-service, we think PPOs would show up, they think no one would show up.

Even when you get to the point where you are paying 103, 104, 105 percent of fee-for-service, CBO still assumes it will not be attractive enough for plans to bid, and we believe that plans will bid in big numbers. It is just a fundamental difference about how well these things work.

Mr. Holtz-Eakin. If I could expand on that just one bit. In this particular language, there is relatively little difference from current law. There is somewhat of

a bump-up in the M+C payments, and as a result, in our view, the landscape is not dramatically different under this language than it is now, and at present M+C plans do not exist nationwide.

They exist only in a minority of the geography, and they serve locations which cover only 60 percent of Medicare beneficiaries. PPOs have the opportunity to enter now and have chosen not to, and we do not see a dramatic difference underneath this language that would cause a lot of PPOs to emerge. That is the heart of why we have so few people in them. It is not that they do not choose to go in, they simply are not available.

Senator Santorum. Is the big difference not, though, that we are adding a drug benefit now, that HMOs basically are offering without being compensated for offering it? Is that not a pretty big difference?

Mr. Scully. We believe--and again, we have had this debate on a friendly basis for the last couple of months--that HMOs only exist in urban areas. They generally do not exist in rural areas. They can pick counties, and cherry-pick counties, and not go into other counties.

As a result of that, when we disconnected the formula in 1997 from average spending in Medicare, what happened was, rural areas frequently, as was mentioned earlier, go up to 130, 140 percent of fee-for-service and no one has

shown up. Many of the urban areas like Philadelphia are at 86, 87 percent of fee-for-service so they are significantly less. On top of that, they have to carve out a drug benefit.

So two things are happening here, we believe. One, is the rate is going up for fee-for-service, plus, instead of an HMO or a PPO to carve out a drug benefit, they are getting roughly a $1,200 new subsidy on top.

In addition to that, we believe the PPOs will work because they are going to have to bid on the attractiveness, in many cases, of the urban areas. It depends on where you are. But they have to take an entire region, one-tenth of the country, so they basically cannot cherry-pick counties. So we believe the rates--again, our actuaries believe--are going to be very attractive for private health plans to get back in. I think it is a fundamental philosophic agreement.

But if CBO is correct, the program will not change at all. If we are correct, I do not think anybody loses, to be honest with you, either way. It is a fundamental philosophical disagreement.

If we are correct, you will have a very big change of people choosing to get into different health plans and getting better benefits. If we are not, then our theory is wrong and it will not work, essentially.

The Chairman. All right. I have got three members on this point. So I would call on Senator Baucus, then Breaux, then Daschle.

Senator Baucus. Just following up, I am sure some seniors listening to this discussion say, well, gee, maybe there is going to be a lot of competition here. What assurance do I have as a senior that I am not on the short end of the stick, that is, that my benefits are going to be less than they otherwise would be? What do we have in this bill to prevent that from happening?

Mr. Scully. The only thing I can assure you, Mr. Chairman, and I am sure Doug would agree, Linda, and everybody else, is every single senior in America will get a higher subsidy and more benefits under this bill than they get today. They also will have, at the very least, the existing Medicare program, plus a 70 percent subsidized drug benefit on top of it.

Senator Baucus. I understand that. But I am saying, all things being equal, assuming that, as a senior I might think, gee, I understand seniors get more generally because this is a $400 billion bill, but still I am worried about being gamed.

This plan is trying to save money, more competition. It goes back to an earlier point. But just for those listening and the seniors concerned, what safeguards are

there here to prevent myself, as a senior citizen, or any senior citizen, from getting gamed by this?

Mr. Blum. Well, Senator, the Chairman's mark would include various protections to ensure that beneficiaries have plans that are fair to them. For example, we have kept all the current Medicare+Choice consumer protections in place to ensure that beneficiaries are not gamed by these new health plans.

Dr. Fowler. They also must provide the current A and B benefits.

The Chairman. Senator Breaux?

Senator Breaux. I would just make the observation that when Mr. Holtz-Eakin and CBO are comparing the cost of preferred providers providing the health care versus the existing Medicare program, he has to assume that Congress, over the next 10 years, is not going to increase the amount of money we give to providers, which everyone in this room knows is not correct in the real world.

But when he has to compare the costs of PPOs with the Medicare program, he has to assume that Congress will never increase the reimbursement rates to providers. Just today, we have four pages of reimbursement increases to providers.

We know that every year we are going to continue to

do that and increase the cost of Medicare. But you cannot correctly assume that in your estimates of the differences in the cost. Is that not correct?

Mr. Holtz-Eakin. That is correct.

The Chairman. Senator Daschle?

Senator Daschle. This may go to Senator Breaux's question. But given what we have all understood to be the comparability between plans, between what is going to be offered under Medicare and PPO, I understand CBO still has about a $12 billion new funding score for PPO under this bill.

Why would there be $12 billion in additional funding if there is comparability across the board?

Mr. Holtz-Eakin. That estimate is the combination of the PPOs plus the HMOs, and reflects the increase in HMO payments, going to 100 percent of fee-for-service, for example, in the bill.

Senator Daschle. So, in other words, this is a shared cost. It is not directly attributable to PPO payments themselves.

Mr. Holtz-Eakin. That is correct.

The Chairman. Senator Santorum, on this point. Senator Graham, also on this point?

Senator Santorum. No, mine is not on this point.

The Chairman. All right. Senator Graham, on this

point. Then I have to call on Senator Lincoln.

Senator Graham. On the last point, could somebody walk through how the money will get from the Treasury to the HMO/PPO group, how it will get to the stand-alone prescription benefits, and how it will get to traditional fee-for-service in the event that there are no other options?

Mr. Blum. Starting in 2006, comprehensive health plans, both the HMOs and the PPOs, would be required to bid for a contract to the government. The government would set a benchmark or a maximum contribution paid to a health plan, but the plan would be paid their bid.

That benchmark would be based on the higher local fee-for-service costs for that county or the current Medicare+Choice payment rate that would have taken effect had this new policy not gone into effect.

For the fee-for-service program, there is no change in financing the way it is----

Senator Graham. Can I ask, you said they are going to be bidding this.

Mr. Blum. Correct.

Senator Graham. But the fall-back will be the 95 percent of the local fee-for-service rate?

Mr. Blum. The current bidding mechanism in the Chairman's mark would set the maximum contribution paid

to an HMO or a PPO the higher of the local fee-for-service rate for that county or the current Medicare+Choice payment rate. But there is no change to the way the government would finance the current fee-for-service programs, so those funds would still be set in their current format.

Senator Graham. So incorporated in that fee bid will be the cost to the HMO or PPO of providing an actuarially equivalent drug plan to its members as is being provided to those in a stand-alone prescription drug plan or traditional?

Mr. Blum. Just to clarify one point. The first bidding mechanism would only apply to the current Part A and Part B benefits that are currently provided to beneficiaries.

HMOs and PPOs would bid for their Part D drug benefit the same way that stand-alone drug plans would bid for their benefit to ensure that Part D benefits do not cross-subsidize Part A and Part B benefits, and vice versa.

Senator Graham. And could you explain to me how that bidding for the stand-alone prescription drug system will operate?

Mr. Blum. Sure. In the Part A and Part B context, we have a comparison point for what a plan should cost

relative to fee-for-service because we have a fee-for-service program currently in place. But there is no comparison point for a Part D drug benefit yet because Medicare does not currently offer a drug benefit.

So there is not this kind of maximum contribution concept that we can look to, so instead the Chairman's mark would set a benchmark based upon the average of all plans' bids for a Part D drug benefit, both the stand-alone plans and the comprehensive plans that offer drug benefits.

Senator Graham. Can I ask one last, kind of chronological question? The way I understand this will impact on the beneficiary, is that beneficiaries will start enrolling May 1, 2005.

Mr. Blum. The benefit would start January 1, 2006. During the first seven months before that period starting May 1, beneficiaries would have an open enrollment period in which to sign up for the Part D drug benefit, but beneficiaries would choose the plan during November, prior to January 1, 2006.

Senator Graham. I think you have just answered my question, because I know that the actual plans are not determined until September of 2005. So, they would have two months after the plan was negotiated to decide which they wish to select. Is that right?

Mr. Blum. Right. That is similar to the current process for the Medicare+Choice program. More beneficiaries get their handbook about October 1, but then make a choice during the month of November for the next benefit year starting January 1 of next year.

The Chairman. Before Senator Lincoln asks her questions, I have a couple of suggestions. Number one, I wanted to announce that Senator Baucus and I do not want to break for lunch. We want to go right through here.

Second, if per chance people who are still on the list have questions that relate to amendments they are going to bring up, I would wish that we would deal with that when you bring your amendment up because there is no sense in plowing the same ground twice, especially in the days of minimum tillage.

Third, we are kind of abusing here, because people have been in line for a long time. I do want to finish an item, so if somebody has a question on that point, but do not ask for the floor, please, out of order if you are not on that point that we are dealing with.

Senator Lincoln?

Senator Lincoln. Thank you, Mr. Chairman. I may have tried to interrupt before, but I was trying not to have to backtrack.

We discussed, when Dr. Frist and Senator Conrad

brought up the issue of the retiree health care, those that lose the 37 percent, is it my understanding that the retiree contribution that is there is not counted in the out-of-pocket expenses in this bill? Is that correct?

Dr. Fowler. I am sorry, I did not hear your question.

Senator Lincoln. The retiree contribution is not counted in the out-of-pocket expense when it is calculated for the beneficiary.

Dr. Fowler. That is right. That is part of the new provision.

Senator Lincoln. So some of the problem we have here, is that what businesses and industries are doing is not being considered. What happens when these beneficiaries hit that gap, then the retirement benefit is having to pull the whole load. Is that correct?

Dr. Fowler. That is right. The contribution by employers would not count toward the out-of-pocket spending on behalf of the beneficiaries.

Senator Lincoln. So why do they have any incentive to keep these? I do not think that the 37 percent should be an astonishing realization to us.

Mr. Lieberman. Senator Lincoln, I think there is a little complexity here. In general, the first level of the benefit, from $275 until the $4,500 of drug spending,

that is available to everybody. There is no true out-of-pocket there.

So if you are an employee or former employee who has employer-sponsored coverage, what would happen, is Medicare would become the primary payor and your employer or former employer's benefits would wrap around that.

But when you move to trying to calculate the catastrophic piece of that so that somebody has high expenses, only the beneficiary's true out-of-pocket costs would count. So if it has been paid by a third party, in this case their former employer, that would not count.

In terms of the subsidy, roughly, and this is approximately right, roughly 70 percent of the subsidy cost is associated with that first level of benefit. Roughly 30 percent of the subsidy cost is associated with the catastrophic level of the benefit.

So from an employer's perspective, they would be getting about 70 percent, as a rough average, of the subsidy that would be available if they were not providing the coverage for former employee.

Senator Lincoln. So you are saying that there is a subsidy provided for the employer plan.

Mr. Lieberman. Yes.

Senator Lincoln. Is it the 25 percent? I am sorry, I never saw what it ended up being in the original bill.

There were many rumors that floated. But maybe that would help my understanding.

Mr. Hayes. The subsidy that is available to retiree plans is the same subsidy that is available for any Medicare Advantage or stand-alone plan for that basic benefit package.

So an employer that meets the qualifications in the program for the beneficiary protections and the amount of the benefits and so forth, that employer would receive, for their qualified beneficiaries, that same subsidy that would apply toward the benefits provided for them.

Senator Lincoln. At any portion?

Mr. Hayes. For the basic benefit from the deductible up to that $4,500 benefit limit. The issue here is what counts toward the true out-of-pocket limit. I believe the Chairman's mark contemplates directing the greatest degree of resources possible to those who have no coverage at all, and therefore that allows us to have a lower out-of-pocket limit for those who do not have coverage.

It means that beneficiaries that have no additional coverage would only need to spend $3,700 of their own spending to qualify for the catastrophic amount.

Senator Lincoln. The amount is the same for everyone, is it not, in terms of out-of-pocket expenses?

Mr. Hayes. That is correct. That is correct.

Senator Lincoln. But those that do have those plans are not allowed to use any of their employer benefits plan towards their out-of-pocket. But when they do reach the cliff and they go into that gap, then the employer plan covers everything until they hit the catastrophic. Correct?

Mr. Hayes. That is correct. If the retiree plan provides that coverage there, they will still be covered. A beneficiary who did not have coverage could also have contributions from a State pharmacy assistance program or another individual, family member, or that kind of thing, or also Medicaid benefits, also count.

Senator Lincoln. But none of those things count towards their out-of-pocket before they hit that threshold, correct?

Mr. Hayes. Actually, the Medicaid contributions, the individual or family contributions, and the State pharmacy assistance program contributions do count.

Senator Lincoln. Towards out-of-pocket?

Mr. Hayes. Yes, they do. So a beneficiary that has access to those kind of benefits is not penalized in any way.

Mr. Scully. I want to add, Senator, this is something we spent a lot of time on. I think the

committee did a pretty good job trying to find the fine line to not buy out all the employer costs, but to incentivize them appropriately so they can keep them in.

CBO and CMS probably disagree a little bit, but essentially, probably between $500 to $600 per year, if you are an in existing employee retirement drug plan, you are probably buying out $500 to $600 a year of employer costs.

So they may still potentially drop employees, but we are buying out, not as much as they probably would like, but I do not think we want to buy out all the employer plans. But we are clearly cross-subsidizing existing employer plans probably $500 to $600 a year based on what I have heard from CBO.

Mr. Hayes. In addition, the beneficiary spending after they reach the $4,500 limit is $1,312 of their own spending in that gap before they would reach the $3,700. The modifications to the Chairman's mark this morning have attempted to narrow the amount of spending that is in that gap in order to minimize the impact on beneficiaries who do not have any other additional coverage.

Senator Lincoln. In terms of some of what has been talked about in the volatility for seniors in these one-year contract cycles, and I am pleased to see that the

Chairman took some of that into consideration and improved the mark by lengthening the contract two years for the private plans.

But my concern is why we have not lengthened that for the fall-back plans. Is there any way CBO can tell us? I mean, is there a cost involved with that? Nobody seems to know that there is a cost, or if there is, or what it is. What is the problem there?

Mr. Holtz-Eakin. It will depend on the precise specifications, of course, but a ballpark estimate of that would be about $1 billion.

Senator Lincoln. A billion?

Senator Baucus. I am sorry. What was that, again?

Mr. Holtz-Eakin. It would depend, of course, on the precise language. But a ballpark estimate of things like that we have looked at, is $1 billion.

Senator Baucus. A billion for?

Senator Lincoln. For extending the fall-back for two years, just as we do the private plans.

Senator Baucus. Thank you.

Senator Lincoln. I mean, obviously the concern we have in many of our States, is States where these plans have not come now, they are probably still not going to come. If we end up with a fall-back and they do think that there is going to be some profitable way they can

come in, they come in and then they leave, the fall-back is not able to maintain the kind of continuity that these others do.

So I really hope that the committee will take a look at that. I do not think there is any problem with offering the same expectancy and continuity to those plans.

The other thing I would like to ask, if I may, Mr. Chairman, is I never got a clear answer on--I had offered an amendment on insulin syringes being included. Does anybody know if that was included?

Dr. Fowler. We are very interested in that provision. I think we just need to get some assessment from CBO as to what the score would be. I do not know that they were in a position to do that at the time we were considering it and going through all the amendments last night.

Senator Lincoln. So you think maybe we will have an answer to that today, before we end tonight, or what have you?

The Chairman. CBO has told us it is very difficult to score things. But we kind of thought we would consider amendments and not let that stand in a way if you want to offer an amendment. But, under some conditions, I might have to rule those out of order, but

we certainly are not starting with that assumption.

The Chairman. Senator Nickles?

Senator Lincoln. I have two more.

The Chairman. Oh, I am sorry. How many more questions do you have?

Senator Lincoln. Just two. Just two.

The Chairman. All right.

Senator Lincoln. And I will be finished, I promise.

The Chairman. Quickly.

Senator Lincoln. One of the other initiatives that I have on my list, Mr. Chairman, and the committee has been great to work with me, was the provision on the GME financing for the second year, which I have inquired with Mr. Scully is something that can be done administratively. It is a very, very minuscule cost, apparently.

The fact that we have 125 medical schools in this country and only three of them have departments in geriatrics, without that second year we are not training any more academic geriatricians.

So it does not really matter if we do not have the physicians to see this aging population what kind of programs we provide them if the physicians are not there to take care of them. So I am just curious to see if there is maybe anything that you can shed on that.

Mr. Scully. I talked to Senator Lincoln about an hour ago and I have been trying to find out if we can do it administratively. I have been to the Little Rock Geriatric Program. It is a great program.

If we can do it administratively, we are certainly willing to try. If not, we will try to figure out what the cost impact of the amendment would be. I will try to get ahold of the staffer at CMS who does this.

Senator Lincoln. Great. I will look forward to working with you throughout the day.

I would just like to add to the comments that Senator Conrad brought up about the Part B deductible increases from $125, which you said, if it is indexed, ends up being $152.

I want to just make sure we are all very aware that there is still going to be a $250 deductible in the drug part and I think that there is still going to be a lab co-pay that will be a part of what beneficiaries pay.

Maybe CBO can give us some kind of idea of what the list of each of those increases are, and what the overall increase to beneficiaries is actually going to be as we move forward in this. I think that would be very helpful to have a better understanding.

There are bits and pieces out there, but cumulatively I think, just to understand what is going to be shifted

to the beneficiary, would be very helpful. Thank you.

The Chairman. Senator Nickles?

Senator Nickles. Mr. Chairman, thank you very much.

I might ask a technical question of staff. You basically have a couple of different benefits here, but the low-income benefit was increased from 150 percent to 160 percent of poverty. Is that correct?

Ms. Fishman. That is correct.

Senator Nickles. Did you just strike the 150 and go to 160, or do you have a different category from 150 to 160?

Ms. Fishman. No. Those individuals get the same as what the people at 150 get.

Senator Nickles. So basically they get a benefit that is 10 percent co-pay, and then in the donut area it is 20 percent co-pay, then a 10 percent co-pay for catastrophic. Is that correct?

Ms. Fishman. Yes.

Senator Nickles. All right. Let me ask either staff, or Mr. Holtz-Eakin, or Mr. Scully, what percentage of Medicare eligibles are 160 percent or less?

Dr. Fowler. We believe it is somewhere around 37 percent.

Senator Nickles. Are you including Medicaid dual eligibles?

Dr. Fowler. Yes.

Senator Nickles. I do not think that is accurate. I am interested. Mr. Holtz-Eakin, do you have that answer?

Mr. Holtz-Eakin. I do not have that number, no.

Ms. Fishman. Excuse me. I believe it is 44 percent.

Senator Nickles. Forty-four percent was what I had. But we have had a significant discrepancy in numbers and I think that is very significant. But 44 percent is what I am showing. We, I believe, got that number from HHS and so on. So is there agreement amongst staff on that? So, it is 44 percent.

Now, let me ask a couple of questions about that. If it is 44 percent, I might ask further, the next level down or the 135 percent or less, that is equal to 36 percent of Medicare eligibles, is that not correct?

Ms. Fishman. I apologize, Senator Nickles. I did not hear your question.

Senator Nickles. All right. The percentage of Medicare eligibles below 135 percent of poverty.

Ms. Fishman. Below.

Senator Nickles. I show it as 36 percent.

Ms. Fishman. Well, CRS just presented us with a table that shows, below 160 percent of poverty, if one

uses the QMB definitions, is 37.4 percent; about 12.46 million people.

Senator Nickles. I would like a copy of that chart, if I could get that.

But anyway, so what?

Ms. Fishman. It is 37.4 below 160 percent.

Senator Nickles. Now, wait a minute. That does not make sense. This is a big difference. You have enormous subsidies below 160 percent as compared to everybody above that level. I have been trying to find that figure, Mr. Chairman, and I have been wrestling with it. I happen to think that 44 percent is correct.

I am going to ask for further clarification from both CRS, and Mr. Holtz-Eakin, I asked you that question, I think Senator Conrad and I did. Do you have that answer?

Mr. Holtz-Eakin. The staff is actually working on that right now and we will get it to you as soon as we can.

The Chairman. And I think if Senator Nickles has problems getting a definitive answer on that, we need to get all the people that are involved in making that determination in the same room so we get a consensus.

Senator Nickles. Absolutely.

The Chairman. Because he is entitled--we are all entitled--to know the figures.

Senator Nickles. Mr. Chairman, this is interesting. If the actuaries are so good, and I have been wrestling and trying to get the answer to this for days, you are talking about billions, and billions, and billions of dollars of difference in cost.

Because the people below 160 percent, basically, the government is going to pick up at least 80 percent of all their costs and the people below 135 percent--and staff, correct me if I am wrong--of poverty, the Federal Government is going to pick up at least 90 percent of all their drug costs, including the donut. There is no donut, no gap. I am concerned about it.

I am concerned about over-utilization. I am going to ask a question about that. But I would like to know if we are talking about 37 percent or 44 percent, and I think that would be helpful. I will let some of the staff keep working on that.

Mr. Scully. Senator, you are correct. It is 44 percent over 160.

Senator Nickles. Under 160.

Mr. Scully. Under 160. It is 38 percent under 150. I have a chart I will give you in a second. I think the difference is, when you use the QMB test, it takes out assets and it changes the numbers. So whether you count the asset test or it is just income, is a totally

different definition so you get a different number depending on the definition of whether you count assets as part of the test or not.

Senator Nickles. I appreciate that. But what is critical right now, you are talking about income, not assets as far as eligibility, to participate where the Federal Government is going to be picking up anywhere from 80, or 90, or 95, or 97.5 percent.

My concern is, Mr. Holtz-Eakin and others, I have great respect. My opening comment said I think, in the year 2013, we are going to come back, and this thing will have cost more than $800 billion.

I have only been doing budgets for only 20-some-odd years, but I think every estimate of new entitlements has usually missed it by multiples. I can easily see whatever donut hole we have being filled in the future and it will be expanded by future Congresses.

But I am really concerned about how much it is going to cost. This is misunderstood by some. I have complained--and I may or may not have an amendment, Mr. Chairman--and am concerned about our subsidy level being so high that we are going to encourage over-utilization, even under the so-called insurance system.

I cannot help but think, under the system that is designed, you can still have a Medicare beneficiary for

health reasons or whatever reasons going to different specialists, asking for prescriptions, a doctor writing it, and it being paid, and maybe going to multiples instead of having an integrated benefit as is done by most PPOs and others.

In other words, you might have a lot of doctors, a lot of over-utilization. Plus, and this is one other thing, and I am interested in comment. That is the massive subsidy. The massive subsidy are those people who are less than 160 percent of poverty, and that is about, for a family of two--correct me if I am wrong--$22,500.

So we are talking about a lot of couples who, if their income level is less than $22,000, Uncle Sam is going to be paying at least 80, and in some cases if they are a little less than that, $15,000, we are going to be paying 90 percent of all their drug costs with no limit. Correct me if my facts or wrong, or my statement is wrong.

I would love to be corrected. But my concern is, if Uncle Sam is paying 90 percent, or 95 percent, or 97.5 percent, you could have utilization go up. Then one other point on utilization, and correct me if I am wrong.

The individuals that are at the next highest level that pay the deductible, pay the premium, and only get 50

cents back on the dollar for prescription drugs, they may have an interest in trying to get their money back.

They have heard some of our colleagues say, you do not break even until you are at $1,200. So, they may say, hey, I have to pay the deductible, I have to pay the premium. I am finally going to start getting some money back.

So, therefore, let us see if we cannot run up a drug bill that is at least $1,200 so I can recoup my investment, my insurance. I think that could encourage utilization.

If you put a combination of those, it does not cost 10 cents on the dollar for most of the drugs for people less than 135, 20 cents on the dollar for people less than 160 percent, there is a real encouragement to use drugs. Then for people that are above 160, there is a real encouragement to get their money back.

So I am concerned that the estimates by CBO, by CMS, and by the actuaries may not have that taken into consideration to the degree of human nature.

Mr. Hayes, do you want to comment on that?

Mr. Hayes. I just want to clarify a couple of data points for you. I have a table I would be happy to share with your staff that was prepared with the assistance of CRS that breaks out, at different levels of spending, how

much a beneficiary would pay in premiums.

Beneficiaries that are below 160 percent of the federal poverty level and are not the QMBs, SLMBs, or QI-1s are still charged a premium and still pay a deductible.

So, the amount that a beneficiary save at that level, an average beneficiary, according to CBO, in 2006 would spend $3,155 on prescription drugs. They would get about a 79 percent reduction in their spending at that level of prescription drug coverage.

Senator Nickles. You mean a 79 percent subsidy?

Mr. Hayes. They would have a total savings of $2,482 off of $3,155.

Senator Nickles. So the Federal Government is subsidizing 79 percent.

Mr. Hayes. Yes, sir.

Senator Nickles. And I said 80 percent. I appreciate the correction.

Mr. Hayes. I am sorry.

Senator Nickles. No, I am serious. That is my point. These are super-subsidized, very high ratios, as compared to a lot of other plans for any individual below that level. The people above that level have to go 50/50 for the most part. They are getting a lot less subsidy. Above 160 percent of poverty they are getting a lot less

subsidy than the people below 160 percent.

And below 160 percent--correct me if I am wrong--the maximum they would pay--now, granted, they would pay a $50 deductible if they are in that last category, but the other people above that have $250 or $275. There is a big difference.

They have a sliding scale in that one category. But below 135 percent, they do not even have any premium and they do not have any deductible. All they have is a 10 percent co-pay, is that not correct? Or a 5 percent co-pay.

Mr. Hayes. That is correct. And I apologize, I did not hear you say 80 percent earlier.

Senator Nickles. Yes, I did say 80 percent. So, yes, that one category is 80 percent, but below 135, it is 5 percent with no deductible and no co-pay. So the Federal Government is going to be paying for a couple, at 135 percent, with income of $16,000 or less, 95 percent of the drugs.

I happen to be afraid that that is going to encourage over-utilization. Maybe I am wrong, but I am also concerned about what we are getting. I do not know that, once you put it up at 95 percent, if you could ever roll it back to 80 or 90 percent to make it more realistic.

Any other comment, Mr. Holtz-Eakin? I am going to

call you in 10 years and ask you who was right, if this is closer to----

Mr. Holtz-Eakin. I look forward to the phone call. We appreciate your comments. These are all factors that we have thought of and have done our best to model in producing our cost estimates and made a good faith effort to incorporate the incentives on all sides.

Senator Nickles. Let me ask you another question. You have estimated right now, the present system, if you do not have at least two private sector alternatives, there would be a fall-back. It would be a government system.

It would be CMS basically reimbursing drugs. I guess, as the bills come in, they would be writing checks. Or maybe they would use a pharmacy benefit manager or something like that.

Do you estimate, under your projections, that that is less efficient or more efficient than the private sector?

Mr. Holtz-Eakin. Other things equal, moving from the private sector to the fall-back plans, will be more expensive. There are two factors.

One, there is less incentive to control costs in the fall-back plan because of the features you mentioned, but compared to the private plan there is no risk bearing, and as a result there is no necessity to compensate for

risk. But, on balance, they are more expensive.

Senator Nickles. Mr. Scully, do you agree with that?

Mr. Scully. Yes, sir.

Senator Nickles. I am glad when we can get you both in agreement. I appreciate that.

What is the average cost of Medigap?

Mr. Scully. The average cost of the 10 plans this year for ARP, and there are others that are much higher, is $2,200 for an individual, without drugs.

Senator Nickles. $2,200?

Mr. Scully. For an individual, without drugs.

Senator Nickles. All right. Do you have an estimate of what the average cost of this drug benefit will be added to fee-for-service?

Mr. Scully. The estimate, actuarially, I believe, we think the Senate bill is just under $1,200 for the total package, and obviously 70 percent of it is paid for by the government. So, the beneficiary cost is obviously estimated to be $35 a month times 12.

Senator Nickles. I know what the beneficiary cost is. I am trying to figure out, the balance of that basically is going to be paid for with general revenue funds?

Mr. Scully. About $800 a year per person, on

average, obviously.

Senator Nickles. Mr. Holtz-Eakin, does that sound right to you?

Mr. Holtz-Eakin. Senator, without the administrative costs, it is about $1,270 or so, is the actuarial value.

Senator Nickles. $1,270. So correct me if I am wrong. Right now, the beneficiary would be paying, if they are above 160 percent, or above 150 percent on the sliding scale, or above 135 percent on the sliding scale, they pay some premium.

Once they are at 160, they pay $35 a month. Then they would pay whatever percent of co-pay it might be, whether it be 2.5 percent, 5 percent, 10 percent, or 20 percent, and then the government pays the difference. Is that correct? Out of general revenues.

Mr. Holtz-Eakin. It depends on whether, as you said, Senator, it is a private plan at risk or a fall-back plan. The provisions get slightly complicated because there is reinsurance for costs of the catastrophic.

Senator Nickles. I understand.

Mr. Holtz-Eakin. But, in general, if it were a private plan, that plan would make a bid and the government would, in general, before you get into the

risk corridors, would make a payment that would be based on that bid, so the plan would be at risk for profits or losses based on its bid.

Senator Nickles. So the government might make a payment of, let us say, $1,200 and the individual might be paying 30 percent of that cost, and this is coming from general revenues instead of, really, a payroll tax.

Mr. Holtz-Eakin. In that case, the government would make a payment of, I think, if my arithmetic is right, about $420. The government would make a payment to the plan that would be something over $800, or probably around $900.

Senator Nickles. Theoretically, that money is coming from general revenues instead of what we would call our more traditional Medicare 2.9 percent of payroll. Is that correct?

Mr. Holtz-Eakin. Yes.

Senator Nickles. So we kind of have an open-ended entitlement. Where, previously most of Medicare--most of it, not Part B--was paid for with the payroll tax, now we basically have general revenue obligations and we will have to see how much it costs at the end of the year.

We have estimated 400. That is what the budget resolution calls for. We will keep that within that figure as it marches through the legislative process.

Then we will go to reality and find out if consumption and utilization costs meet our expectations.

My guess is, we will find out where the costs are. I hope that you are correct. I am concerned, when Uncle Sam is paying 90 some percent of the cost for 40 percent of the individuals, that it is going to exceed our expectations. That is just my guess.

Mr. Chairman, thank you very much.

The Chairman. Here is what I would like to do. Senator Bunning had a point following on you, then Senator Daschle had a question. Then the staff asked if they could have a five-minute break.

Senator Bingaman. I had one question, too, Mr. Chairman.

The Chairman. Well, all right. Go ahead, Senator Bunning.

Senator Bunning. Thank you. I have been listening. Unfortunately, I went and got something to eat. Since I am on the Atkins diet, you have to eat when you can.

I would like to get into what I heard Senator Nickles speak of on the air, talking about the utilization and who is going to utilize, and what percentage of poverty these people are at. I did not hear him mention the total amount of money that an individual and a couple, dual eligibles, are at.

We are talking about an individual at $6,500 and a couple at $8,800. These are the people that are going to be taken care of by Medicaid. These are the dual eligibles. Then as we go down the line to the QMBs and the SLMBs, and the individual qualified people, that goes all the way up to an individual making $12,000 and $16,000 a couple.

I think this is what the whole benefit is all about. I want to take care of these people as best I can. I have a difference of opinion with my good friend from Oklahoma on this.

I am going to ask CBO and my good friend Tom on the numbers, because I think it is important that we know the numbers. According to the numbers that I got, the truly dually eligibles are approximately 5 million if you exclude the ones that have net worth of $4,000 as an individual or $6,000 as a couple.

In other words, take care of their house. That is excluded. Now we are talking about other assets up to $4,000, or $6,000 a couple. Am I mistaken, in the total amount of people that are eligible, that it is more like 5 million people if you exclude their assets? I am asking OMB or CMS, either one, to answer.

Mr. Scully. The numbers I have, and I would be happy to share this chart with you, is the medically

needy, which generally includes assets, is about 6 million below 100 percent of poverty. Beyond that, there is an additional 2.6 million. Then the QMB, to the low-income SLMBs----

Senator Bunning. Not enrolled presently in something. Are you talking about people who are----

Mr. Scully. That is the total number of people.

Senator Bunning. Eight million people total?

Mr. Scully. That are either SSI medically needy or below 100 percent of poverty.

Senator Bunning. And we are including in that the fact that they have assets less than $4,000, or $6,000 as a couple?

Mr. Scully. That includes everyone by income.

Senator Bunning. All right. That does include?

Mr. Scully. That is the entire population with those income thresholds. The SSI needy usually includes the asset exclusion.

Senator Bunning. That includes the assets?

Mr. Scully. The exclusion of the assets.

Senator Bunning. Exclusion of the assets. All right. And the same thing goes with all the others then, the QMBs, the SLMBs, and the QI-1s.

So the world that Senator Nickles is talking about does include an exclusion of assets.

Mr. Scully. The assets are not counted in this. It is just purely on income.

Senator Bunning. In other words, the total world we are talking about is 16 million people below 160 percent of poverty. It is 16.432 million people.

Mr. Scully. I do not have the exact number, but that is very close.

Senator Bunning. Is that correct? I am not going to fight over 300,000 people.

Mr. Scully. 16.8 million is the correct number.

Senator Bunning. 16.8 rather than 16.432.

Well, I just want everybody to know that is watching this and listening to us discuss this these people are the poorest of the poor in our country and I thought this benefit was being designed to take care of them and not the ones that can actually pay for a larger benefit.

I would like to get in one other thing. We are talking about a monthly premium of $35 and we are talking about a deductible amount of $270. Is that correct?

Ms. Fishman. It is $275.

Senator Bunning. Excuse me. $275.

Ms. Fishman. That is correct.

Senator Bunning. All these details. So it is $695.

Mr. Scully. For the higher income people.

Senator Bunning. Now, some of these are not even included in that. They do not even have a deductible. So the total package we are looking at, and you were telling me, Tom, that $1,200 is the overall total cost to the government for the benefit, is that right?

Mr. Scully. That is the subsidy for the higher income people above 160 percent of poverty. Everybody below 160 percent of poverty gets substantially more than that.

Senator Bunning. I understand, because they have no deductibles and they get 97.5 percent taken care of, 95 percent. But the whole point we have to make sure we understand in looking at this total bill, is this is not for Bill Gates, it is not for anybody sitting at this table today. It is for somebody who absolutely needs it. Unless we understand that, we are going to distort all the questioning that we have here.

All the estimates and nitpicking that we are doing under this thing is going to distort it. We are not going to get this thing perfect. We are going to have to adjust it as we go down the road. I want everybody to understand that. We are not going to make a perfect bill.

The whole point, Mr. Chairman, is that the most needy in our society are the ones that are we trying to target

with this bill.

The Chairman. Thank you.

Senator Daschle?

Senator Daschle. Mr. Chairman, I want to identify with Senator Bunning in that last comment. We are talking about people with $16,000, a couple. That is $8,000 a person. We are talking about people that are buying drugs. They are not buying candy or croissants here. This is drugs they are buying.

I cannot imagine that there is anybody who would be concerned about the over-utilization of drugs. If they are sick, they are going to use them, especially with an income of that level.

So, I hope that we can keep our perspective here. I think we did a pretty good job of taking care of those with million dollar incomes a couple of weeks ago. Their dividend break is going to be about $9,300 this year. So if we can afford $9,300 for those with incomes of a million dollars, it seems to me dealing with this benefit as we are in the bill is appropriate.

But I had a question on the fall-back, if I could. Senator Lincoln had asked the question about why we are only allowing for a one-year contract for the fall-back. As I understand it, the answer was that it is a billion dollar offset issue. If there is another issue, I would

be interested in it.

But I guess what I am wondering, is if somebody could just explain, how does this work? If it becomes apparent that the two companies are not going to be there, the two policies are not going to be available, over what period of time does that criteria, that decision making process, go on?

Then how is it that we contract with another private pay company to provide the policy for the fall-back? Is it possible that we could not find one? How do we incent somebody to come in? Do we mandate that they come in? How does that work?

Mr. Blum. Under the Chairman's mark, the Secretary would make an assessment each September whether or not there were two plans to serve beneficiaries for the next calendar year. The test was failed.

If there were one or zero private drug-only plans for beneficiaries to choose from, the Secretary would have to find or contract with a fall-back option to serve those beneficiaries.

The current Chairman's mark says the contracting cycle for the private drug-only plans would last for two years, whereas the fall-back would last for one year. That decision was made prior to us knowing the score from going to two contract years for both fall-back and

contract plans.

Senator Daschle. So as I understand it, by September the Secretary makes a determination that, for the following calendar year, there are or there are not two private plans available to provide the coverage, and then obviously they would have to be actuarialy consistent, and all of the things we have talked about.

Between September and December, the Secretary, in the cases where there the availability of those two plans is now clear, or the lack of availability, they have to contract with a plan that will be available beginning January 1. How does one ensure that that plan can be found? Tom?

Mr. Scully. Mr. Leader, it sounds like a tight timetable. We basically do this with the Medicare+Choice plans now. They come in, they make their offer. Obviously, many of them have pulled out in parts of the country.

So if we did not have two bids in time in September, we would have to go out and sign a contract. I believe there are many companies out there, many States, that do this. There are many States that do risk-based drug contracts. Some do it where they just have a PBM run the program for them. We think that is a higher-cost way to go.

But I believe there are plenty of PBMs under the contractors out there that, if we found a region where no one showed up to bid, we could, without too much difficulty, have a fairly hefty supply of people. The issue is, they are not going to take any risk. They are basically going to run it on a cost-plus basis and we would be paying.

Senator Daschle. But then why do we not have Medicare+Choice plans in rural areas today if it is easy, Tom?

Mr. Scully. Well, we would have. We still do have some cost-plus. I am not fond of them, but there are still a couple of them in the country where Medicare+Choice plans have pulled out. There are a couple of left where you had Medicare+Choice plans that are cost-based.

Senator Daschle. So you are confident, and everybody is confident, that we can find a plan to fill this gap, should they not be available on September 1?

Mr. Scully. I am confident there will be plenty of people willing to come in on a purely, just pay-us-a-contract basis without carrying the risk.

The issue is, if it happens that the benefit is not $1,200 a person, it is $2,000 a person, the government is the one who is going to lose. The issue here is the

risk. The Secretary, under the bill, is authorized to keep narrowing the risk quarters to draw beneficiaries in, to draw plans in by region if they do not show up.

If, eventually, they do not show up, we are authorized, essentially, to carry all the risk and just pay a contract to a PBM to administer the program for us. I am certain there will be contracts.

Senator Daschle. And from your experience, is it is an advantage or disadvantage that these contracts would only be one year?

Mr. Scully. I think initially they did it for scoring reasons. But I think it is possible. I think there will be plenty of people showing up on a risk basis, personally.

But the obvious concern is, if that does not happen, that there be somebody there to provide the benefit. I think, as this program gets going initially, it is possible that people may not show up in some region initially.

As it works in other regions, they may show up. So, initially, if you do not have someone show up in one year, once they watch the experience in that region and think it might work, they might well show up a year later for a bid. So, I think it makes some sense.

Senator Daschle. I am sorry. So you think it is an

advantage that it is only a one-year contract for the fall-back?

Mr. Scully. Yes. You may find that someone actually has a risk, let us say, in the upper midwest region, which includes South Dakota. If, hypothetically, no one showed up there and we hired Advance PCS to run it in that region without carrying any of the risk, and at the end of the year their cost turned out to be reasonable, I think you might well have many bidders show up the next year.

Senator Daschle. The final question, I guess, is from the perspective of the beneficiary, they are sitting in September, they want to know what their plan is going to be the next calendar year.

How much of a difference, how much uncertainty can we anticipate, given these areas where I expect this is going to be a real problem, getting these two plans to be there to provide the benefits?

Is there uncertainty in that regard? Will the beneficiary know from one month to the next, between September and, say, February, what his or her plan will entail and what that fall-back will mean to them personally?

Mr. Scully. Well, I think there are a lot of good things in the bill for beneficiary education, including a

lot of new funding for the State Health Insurance, the SHIPs, that do a lot of beneficiary education.

But essentially the difference here, Senator, is very similar to what happens to Medicare now. In North and South Dakota, for instance, Blue Cross of North Dakota runs the Medicare program for us on contract with no risk. If there were a PPO up there, hypothetically they may be the one taking risks.

It would be the same with drugs. You may have a PBM that decides to come in and run this based on risks and think they can make a margin. If they are worried about the risk, I believe they will show up without any risk and administer it for us for a 4 or 5 percent fee, which is usually what happens.

Senator Daschle. But I guess what I am asking is, how much uncertainty is realized by the beneficiary as this process of decision making and contracting goes forth?

Mr. Scully. It is a tight squeeze every year with Medicare+Choice now, Senator. But I think, generally, the goal is that, by the middle of October to early November, we mail out every year 41 million brochures to every senior, we have a very extensive web site, we have a 1-800 Medicare number we spend $80 million a year on now that is open 24 hours a day, seven days a week that

can answer unbelievably detailed questions about this coverage in South Dakota.

I think it is always a challenge, but I am fairly certain that, by November 1 of every year, which is the goal, is to kind of make it like an open season for federal employees, that seniors for the months of November and December would have plenty of information to make decisions.

Senator Daschle. Well, I guess I am just very concerned, Mr. Chairman, about the lack of certainty, the confusion, the complexity. I can think of seniors in South Dakota who may not even be capable of all of this. I am wondering just what happens in those cases as we go forth.

The more we can allow for certainty, stability and simplicity, I think, the better off it is going to be for a lot of people who are maybe in their 80s or 90s who are not capable, or certainly not desirous, of having to make all these choices and these decisions.

But, again, I thank Tom for the answers.

Senator Baucus. Mr. Chairman, I would say the Senator from South Dakota makes a very good point. Maybe the seniors in South Dakota are a little better able than seniors in some other parts of the country.

But it is a big question and it is clearly one we are

all wrestling with, clearly one we want to give more certainty. I am hopeful, either during this mark-up here or during the day we could find a way to begin to address that, and if not, then certainly before we get to the floor. But it is, I think, the central question and we need to certainly face it.

The Chairman. Yes. I thank you for your point. I probably would not have the same concerns that Senator Daschle has, but at least part of the concern he had. I wanted to address--and do think we have addressed it, but obviously not far enough--that I want to make sure that everybody in rural America has access to drugs.

That is why I was very willing, in an unquestionable way, even though I had worked two years on the tripartisan plan, to make sure that we had a back-up. We do have a back-up. There still may be some questions about it. I am surely willing to entertain any of those questions.

Right now, I do not think I am convinced to go further. I think we ought to be satisfied on these things. If you want a back-up and a back-up is not adequate, then a back-up is not a back-up.

But at least I got over that hurdle very easily because we do want to make sure. If there is any question about a new plan going into place, then we ought

to take some of those questions out, but I do not know how far I can go yet.

Did you have a question?

Senator Conrad. I have two questions.

The Chairman. Before you ask your question, here is what we will do, then. When he is done, we are also going to have a vote at 2:30. So then we will have our break for you folks that have not had a break for, now, four hours, to take a break. Then when we come back, we started out with 138 amendments filed. We have had 32 worked out. We have had some amendments that, it looks like, will not be offered.

But it still looks like we would have approximately 31 amendments on the table that could be offered. Obviously, Senator Baucus and I hope those all will not be offered. But then we would start on amendments when we come back after the vote. It would be my hope that all of us could vote early and come back.

Proceed.

Senator Baucus. If I might, on that point, Mr. Chairman.

The Chairman. Yes.

Senator Baucus. Because we need at least seven or eight members to do business on amendments, it would be a good time for Senators, after the vote, not only those of

us who are here now, but those of us on the committee who are not here now, their staffs can tell them that we are going to start working on amendments right after the vote. We need seven or eight people.

The Chairman. Hopefully, our staff has been working to find an orderly way and a fair way to work on these amendments, and maybe I can present that to the committee and there would be agreement what the staff has decided the order that would be appropriate.

Senator Conrad. Mr. Chairman and Ranking Member, on the subject of amendments, I had noticed eight amendments, you have accepted two of them. A third one, we have talked about trying to find some way to deal with before we go to the floor, so I will not offer that here.

That takes me down to five. I am ready to further reduce that. I would say, I have one amendment that Lewin says in their scoring does not cost anything. That is the self-injectable coverage, transitional coverage. CBO does not have a score.

I wonder if, in a situation like that, I do not think it is controversial at all. I think there is broad support on the committee if it does not cost, if it actually saves money, which is what Lewin believes.

In their analysis, it saves money to allow people to inject themselves at home rather than traveling to the

hospital or the clinic that, in a rural area, may be 100 miles away.

If CBO were able to find out, because they have just not had a chance to score it, that it does not cost money, that could be offered in a manager's amendment at a later time.

The Chairman. Well, why do you not ask your two questions, and let us visit about that.

Senator Conrad. All right.

The Chairman. Because I would like to keep questions about amendments at the time people bring their amendments up.

Senator Conrad. I am just suggesting, maybe there is a way that we can reduce the number of amendments that are pending if we find that, really, they do not cost money and they are not controversial in terms of policy.

In terms of questions, there has been a lot of talk about how private plans will not be offering richer benefits. I have been told there would be no special incentive for seniors to go into HMOs or be pushed into them, but it appears to me that the mark does provide that Medicare Advantage will offer beneficiaries a richer benefit package in at least two ways.

One, is it not true that the mark requires that Medicare Advantage offer a maximum limitation on out-of-

pocket expenses?

Mr. Blum. Yes, that is correct, for Part A and Part B benefits.

Senator Conrad. And does traditional fee-for-service Medicare offer that protection?

Mr. Blum. No, it does not. But the payments to HMOs or PPOs will not reflect the costs for that catastrophic coverage.

Senator Conrad. It will not?

Mr. Blum. No.

Senator Conrad. Well, how do we know that? All money is fungible. We are increasing the funding to HMOs here by $10 or $11 billion. How do we know that that will not be the case?

Mr. Blum. The payment mechanism sets a benchmark for HMOs and PPOs so that the higher of the local fee-for-service costs or the Medicare+Choice payment rates, plans have to offer the A/B benefit, the standard benefit, within that payment limit.

But the plans can either bid below that benchmark and then fund some of the savings for those benefits or they can charge beneficiaries more for those benefits if the plan bids above the benchmark.

Senator Conrad. All right. Let me ask this question. The mark says that Medicare Advantage plans

"would be required to provide disease management in chronic care services and to provide access to preventive benefits." Does traditional Medicare cover those services?

Mr. Blum. The traditional program provides coverage for certain preventive benefits that are provided in statute, but not all preventive benefits.

Senator Conrad. And how about the question on providing disease management and chronic care services?

Mr. Blum. There are several demonstrations that CMS is currently in the process of running to test various models for those demonstrations, but they are not part of the statutory benefit.

Senator Conrad. They are not. I think that is the point here. You have got a structure that, at least on the face of those elements, is offering a richer benefit package than traditional Medicare.

Let me go to my second question, which goes to payments to managed care. A number of studies have shown that Medicare pays more to managed care plans to cover seniors than Medicare would pay if those same seniors were in traditional Medicare. Yet, the mark provides increased payments to managed care plans compared to current law. Is that correct?

Mr. Blum. Currently, for calendar year 2003,

according to MEDPAC, Medicare+Choice payments are, on average, 4 percent higher than local fee-for-service costs. For our Chairman's mark, we estimate that that percentage will stay roughly the same for 2006.

Senator Conrad. There is more money being provided and already they are costing more than traditional fee-for-service care. If the idea here is to save money, why on earth are we providing $10 or $11 billion more for those plans?

Mr. Scully. Do you mind if I answer part of that Senator? I know you love it when I jump in on these things.

Senator Conrad. I was very much looking forward to this.

Mr. Scully. I know you are. I would be happy to.

Senator Conrad. Go ahead. You take a swing at it.

Mr. Scully. I think part of it is, and this, again, gets back to when we detached the fee-for-service and the APCC rates in 1997, what has happened is, the Medicare+Choice plans have stayed in when the rates have been high and dropped out when they were low.

So in urban areas like New York, Philadelphia, Detroit, Miami, Los Angeles, the rates are well below 95 percent of APCC, in many cases as low as 84 or 85 percent. So a lot of the places where the payments were

high or used to be close to fee-for-service and they have dropped, plans have dropped out, obviously, plans have stayed in where they have been higher. So the plans are not dumb, they follow where the rates are.

Senator Conrad. But is that not the point, Tom? I mean, if you have got a circumstance in which those plans are now, according to the testimony of Mr. Blum, at 104 percent of traditional Medicare, and now we are going to increase their compensation even more, it seems to me that is kind of a losing proposition if part of the idea here is to save money.

Mr. Scully. But most of the money is actually going to take the people who are at 85 or 86 percent of fee-for-service and bring them up to 100, because that is where you have lost the coverage, in New York, in Miami, in Philadelphia. The big cities are where the plans have dropped out.

The bulk of this money in the Medicare+Choice plan is actually going to where the rates have dropped radically to bring them up. There are some places that are going to stay higher, but most of the money here is going to buy up places that are well below 100 percent of fee-for-service.

Senator Conrad. All right. That is a creative answer, and I am sure it is true as well.

I thank the Chairman very much.

The Chairman. All right. We will recess until after the vote and we come back immediately after the vote.

[Whereupon, at 2:30 p.m. the meeting was recessed.]

AFTER RECESS

[3:09 p.m.]

The Chairman. Senator Baucus and I have agreed that we would like to handle the amendments this way. If there is no disagreement, we will proceed this way. Based upon members who are here, we will go a member by seniority.

That member would pick any one of his or her amendments that they have filed to bring up. Then we will go back and forth, one Republican and one Democrat, and back and forth that way.

Then when we get done with the first round of seniority, we will just let anybody jump in with an amendment on the second round.

I am hoping that, during the arguments on amendments, that we would not, as I said before, plow the ground again on points that have already been made. The first person with amendments that have not been handled by our committee one way or the other would be Senator Kyl, because even though you are down in seniority, between you and Senator Hatch, the people are not here.

So, we would let you pick any one of your amendments. Just identify for us which one you would like to have it be, and then we will go to you, then we will go to a Democrat.

Senator Kyl. All right. Thank you, Mr. Chairman.

Senator Daschle. Mr. Chairman? Could I just ask a question? Excuse me, Senator Kyl.

Senator Kyl. Yes, Senator.

Senator Daschle. You had said something earlier about the score and the offset issues. You may have said it again and I just missed it, but could you clarify what you want to do in that regard?

The Chairman. Well, in a strictly technical way, I think Senator Baucus would agree to this. But we are not going to do it in a technical way. We could rule a lot of amendments out of order if they were not scored or if they scored over. There is a precedent in this committee to do that, in a very rough way, by communicating with CBO.

But I think we feel, because this is such a new program, we are not going to stick to those technicalities, at least to start with, and entertain the amendments without that sort of ruling out of order at this point.

Senator Kyl?

Senator Kyl. Thank you, Mr. Chairman.

The amendment that I would propose for consideration is the Kyl Amendment #4 which relates to the competitive bidding for the PPOs.

Let me describe, just very briefly, in rough terms, how the system is proposed under your mark and then how my amendment would cause it to be different. Also, we will have a question for Mr. Scully in just a moment, after he is seated.

Let me say, one of the things we are trying to do here, is to give people a choice. They can stay in the traditional Medicare with an enhanced drug benefit, or we believe, especially for those who have grown up in the private sector with PPO plans, they may like to opt for the option which primarily allows them to enroll in PPOs and receive their drug benefit and Medicare services in that way.

The actuarial value of the services are the same, but there is some view that a lot of folks that are in the workplace today are more familiar with the PPO kind of option. They like it. The PPOs could actually provide this coverage better, and potentially cheaper, so we have established this PPO option.

The question that some of us have is whether or not this option is destined for failure before it even gets out of the date. That has to do with how it is set up and how it is accepted by the Federal Government, or authorized to offer benefits.

We like to say that the comparison is to the FEHBP,

and there are a lot of similarities. But there is one big difference. The PPOs in FEHBP do not have to bid for the Federal Government to accept them to offer services to us. We have decided that, for Medicare, however, they are going to have to bid. The method of bidding is important.

What the administration proposed, was that the companies that want to offer this service bid and the three lowest bids will be accepted with the reimbursement rate to the PPOs being the middle of the three.

That is obviously a way to constrain costs, but it is also a way to let the market work. That seemed like a pretty good idea. I do not like it as well as the FEHBP process, but we are really concerned about costs here and that is at least a step in that direction.

The problem is, CBO says that people will participate in that kind of a system, and therefore it ascribes a certain cost to it. But CBO says if you do it a different way, nobody will participate.

So the authors of the mark say, well, since we want to squeeze as much benefit into this as possible, why do we not propose a bidding system that does not cost very much because nobody will participate?

CBO says that 2 percent of people will participate in the system that is represented by the Chairman's mark.

The reason is because there is an artificial cap, a limit, on how much the government can reimburse the providers under the mark.

That is so because a benchmark is developed by the Federal Government which is essentially, as I understand it, the higher of the Medicare+Choice or the Medicare fee-for-service program in a particular region. That becomes the amount of money that will be reimbursed as a cap to the PPOs bidding under the Chairman's mark.

The theory here is that they will all compete, so they will come in under that. But according to CBO, by ratcheting them down to that extent, you are only going to get 2 percent participation because they cannot really offer the kind of benefits that would attract people to the plans.

Our concern is that, obviously, that is starting out almost destined to fail. We do not want to promise people something and then see it fail.

I think Senator Conrad made a point a while ago that I thought was very important. We need to have a good discussion of this. We need to try to walk through it, explain it all, understand it, and make sure the people understand it, because we are going to have a lot of explaining to do if it does not work well.

I am afraid that people sign up for one of these

benefits, and then the same thing happens that has happened frequently with the Medicare+Choice, especially in the more rural areas of the country, where companies started out offering Medicare+Choice and then had to drop the coverage because they just could not make it work. People are very upset about that in my own State of Arizona, for example.

We do not want that kind of thing to develop here where we entice people into a system, we say it is a good thing, and then it turns out not to be able to work simply because we put an artificial constraint on how much the PPOs are going to get paid. In effect, there is a capitation rate.

PPOs say, if the government will give us this much money, we will take care of people. That capitation rate--I know that is not what you like to call it, but it is similar to that--is too low in some areas for the coverage to be provided.

In some other areas, it is probably too high. But I do not think we should freeze out the beneficiaries in the high-cost areas or over-subsidize the beneficiaries in the low-cost areas simply because we are not smart enough to know exactly where we should set that level.

Now, Tom Scully has really educated me a lot about this. He said, in the past, CBO and CMS have had some

bitter fights over estimates that are about a half a percent apart because we use different assumptions and we really get excited about these minor differences.

Here, we are like 40 percent apart. CMS says, we still think that 40-plus percent, 42, 43 percent will participate. CBO, as I understand it, says 2 percent will participate. That is a big gap. In something as important as this, we should not be going into this with that big of an uncertainty. It is just too important.

So, it seems to me that the best way to solve the problem is to simply take the three lowest bids, the median of the three, or the middle of the three bids is what will be reimbursed to the providers, and let the market work and see how it works. That is exactly what this amendment does.

Now, let me make just two other comments, Mr. Chairman. I do not want my remarks to be misconstrued as suggesting some kind of malevolent intent, or even inappropriate intent on your part and Senator Baucus', because you have been very clear that you would like to do something as the administration has suggested here.

But, in order to do as much as we possibly can, we have had to be aware of the CBO estimates and we all are constrained by them. You, as the Chairman, have had to, therefore, put together a plan with those CBO estimates

in mind.

As I understand it, that is the only, or least the primary, reason why you modified your mark away from what the President had suggested to this benchmark kind of approach.

What we have done, is to talk to the administration, which would very much like to see us move more toward what had originally been proposed. I know Secretary Thompson has had conversations with you, Mr. Chairman, and I believe with Senator Baucus.

It would be my intention here, if we can have a brief discussion of this issue today, to raise the issue so that all of us understand what it is all about, and then to get a CBO score. My understanding is that the Leader's office had asked for a score. I am not sure what the status of that is.

But can we, in fact, get a commitment to get a score for this proposal so that we can then begin to make some comparisons, and if it is appropriate, to work out a modification of the mark which looks more like what had been proposed with the three competitive bids?

Mr. Chairman, if you and if Senator Baucus are willing to do that and to work with those of us who support this, as well as the administration, and if we can get a CBO mark, then I would be pleased not to ask

for a vote on this amendment, but rather to hope that we could work it out and present something in time to have it worked out on the floor.

But I do think it is important for us to reach some kind of understanding of what we would like to do if we could, and then try to work toward that process.

Now, there is a great deal more than I would like to say, but let me just stop at that point because I know there are a lot of others that have ideas on this as well.

And could I perhaps ask the representative from CBO if it would be possible, within the next several days, to get an estimate as to what this amendment would cost so that we can understand whether it would be possible to move in this direction?

The Chairman. Mr. Lieberman?

Mr. Lieberman. Thank you, Mr. Chairman.

Senator Kyl, yes, I suspect and very much hope we can get you an estimate in the next several days.

Let me try to review a couple of pieces very quickly, Mr. Chairman, and try to give you the moving pieces and try to answer the question of the amendment that we priced at the request of Leader Frist.

First, with respect to the moving pieces, on the one hand, there is, what does it cost the plan to deliver the

services? On the other side, there are really three pieces.

The first piece, is what do the benefits look like in the private plan compared to the benefits in the traditional fee-for-service? Are they the same or are they richer? If they are richer, obviously, that will attract more people.

The second moving piece, is what does the beneficiary have to pay? Does the beneficiary pay the same amount for the same benefit? Does the beneficiary pay more for the same benefit? Does the beneficiary pay less for a greater benefit? Those things will clearly affect how attractive a plan is for a beneficiary.

Lastly, the question is, how much does the Federal Government wind up paying? If there is a richer benefit package or if it costs more to have a private plan provide the same benefit package, does the Federal Government pay that difference or does the beneficiaries pay that?

Now, to cut to the chase, Leader Frist had asked that we price a proposal that had a relatively more generous benefit. In that case, we estimated that it would cost $100 to $110 billion and that there would be about 20 percent participation in the Advantage program.

Now, your proposal is somewhat different, if I

understand it from discussions with your staff, because what you are asking for is a benefit that is actuarialy equivalent.

Senator Kyl. That is correct.

Mr. Lieberman. One that is exactly equivalent to the traditional A/B benefit, although there would be the ability to have flexibility in changing cost sharing and other things. That benefit would then have the bidding structure which you described. It is clearly going to be significantly less than $100 billion. I cannot give you an estimate, unfortunately, right now.

But I think, as I said, in our estimation--and Tom clearly has a different assessment of the underlying costs, and perhaps of the importance of the mechanism of only three winning bidders--the critical pieces are what is the cost of what you are offering, how richly does that translate to the beneficiary, and who bears the cost?

Senator Kyl. And, Mr. Chairman, if I could, what we need, and we need it quickly, and I do want to get a commitment from you that you will provide it because we are serious about trying to address this, is literally comparing apples and apples.

You take the same plan, but one is bid with the benchmark and one is bid as part of the three lowest bids

and is the middle premium of those three. I realize there is still some variable, but this is the comparison we are trying to make and I think you can understand, therefore, what question to ask us about the design of the plan in order to get to that comparison.

Mr. Lieberman. I think it is pretty clear what you are asking for.

Senator Kyl. Yes.

Mr. Lieberman. We should be able to do that. My guess is that a plan that offers the same benefit with this approach will have somewhat higher costs than what we have seen in the Chairman's mark, somewhat higher participation. But, unfortunately, I cannot be more precise at this time.

Senator Kyl. Right. I appreciate that, even that general statement. Thank you, Mr. Chairman.

Senator Nickles. Mr. Chairman?

The Chairman. Senator Nickles, and then Senator Baucus and I should comment on what he said.

Go ahead.

Senator Nickles. One, let me compliment Senator Kyl and echo many of the things he said. He made a very excellent statement, so I will not repeat it. But I think for us to be successful, we have to have a successful PPO. We have to have a successful alternative

unless we are doomed for failure.

Medicare cannot continue as it presently is for the foreseeable future with a drug benefit added on if we do not have some reforms. It is not affordable, it is not sustainable. So, we need to do something different.

Frankly, we can do something different and better, and I think that is what Senator Kyl is proposing in saying that we should really have a viable PPO alternative. I am not so sure that the benchmark, as proposed, is adequate.

My guess is, we will over-compensate some and we will under-compensate others. I think, CBO, you under-estimated the impact. When you are talking about 2 percent and the White House is talking about 40 percent, there is a big difference.

There is 13 percent right now, I believe--correct me if I am wrong--that are in Medicare+Choice, so CBO is projecting you are going to go down to 9 percent. You are going to lose ground, period, under present law. I think we can do a lot better. I think we can come up with viable alternatives. I think Senator Kyl is offering a viable alternative.

Mr. Chairman, I would hope that you, Senator Baucus, and all of us would have an interest in really seeing a competitive, viable alternative out there somewhat like

what we have on the federal system that can offer better benefits and a more efficient, integrated system. I am not convinced that just adding drugs on top of fee-for-service will work.

I mentioned before, I am really concerned about over-utilization. I think having an integrated health care system where the provider is in charge of basically everything from doctors and hospitals and drugs, can work. So, I compliment Senator Kyl. I think using a market system to determine the appropriate price instead of benchmarks is a much better idea.

The Chairman. Senator Kyl, first of all, I want to mention how cooperatively and thoroughly you have approached this whole issue. We have had many, many conversations about it over a long period of time. You have expressed very strong views because you want this to work.

I hope that I have shown, in the two years that I worked on tripartisan for an alternative to current Medicare, my desires to find something for baby boomers when they go into retirement that will be better than current Medicare.

What we have before us is much better than our alternative that we had in tripartisan. So there is, philosophically, no disagreement between your goal and my

goal.

So, I appreciate your efforts to improve the benchmark on these PPOs. Obviously, as so many parts of this bill, it is a work in progress. This is probably more of a part of the bill that is a work in progress than other parts.

So I hope that we can improve this as we move through the committee and on to the floor and conference with the House. I have been working with my staff on how to design the best benchmark for PPOs way back to January when the President's plan was first talked about.

We talked to actuaries, to health policy experts, working closely with the White House all through the spring. We spent hours with CBO and other support agencies, all with the goal of getting a benchmark that would make the PPO policy an option thrive.

I am not saying that we have here today in the mark a perfect solution, but I think it is a very good start. I hope it is a start that you can live with, with the understanding that it can, and will, improve going forward.

I think I cannot say much more than, I am willing to work with you. We considered the possibilities within the $400 billion to do that, because obviously it would have to come within the $400 billion. So, that is about

all I can say to you. I would appreciate it very much if you would work with us on it and not have a vote on your amendment at this time.

Senator Baucus. Mr. Chairman?

The Chairman. Senator Baucus?

Senator Baucus. Mr. Chairman, I, too, appreciate the remarks of the Senator from Arizona.

Clearly, we have the same objectives in mind here, essentially. That is, a better Medicare system as well as prescription drug availability for seniors, whether they are fall-backs or whether they are in one of the plans.

It is a little bit vexing that we have two wildly different estimates as a take-up rate in PPOs here, from 1, 2, 3 percent to a range of 40 percent. The amendment that you suggest would be one which would probably increase that.

Now, I want to make this bill work and I want to make competition work, because I do think there is a very, very important role for competition here to get costs down. We all agree, too, that we want to make sure the beneficiaries get a good deal. I mean, clearly, when costs are down, beneficiaries get a break here.

I am very committed to work to make this work, the competition side, as well as to make sure that

beneficiaries are getting as good a benefit as we can possibly provide, remembering that we have got a $400 billion cap here that makes it a little bit difficult for us to do some of the things we like to do. But, still, if we can work within that cap, we will actually go to the floor and see what it can do.

The Chairman. Shall we go back to Senator Kyl? Or does anybody else want to speak?

Senator Frist. Mr. Chairman?

The Chairman. Senator Frist? As I mentioned earlier, I really want to refer back to Senator Nickles' earlier comments, to make this program sustainable, we are going to have to do something differently than we have done in the past.

I believe that continuity of care, getting better value for the dollar, plus competition, is really the only answer to be able to fulfill the obligations that we owe our seniors, our seniors deserve, and that we are about to make with this huge increase expansion in benefits by giving prescription drugs.

It is my goal with this unfunded liability, which is going to be billions of dollars in the best of all worlds, looking at the demographic shift, is to make sure that we do everything possible to have competition--yes, regulated competition--as a part of what we are creating.

The difficulty with this benchmark, which is really the heart of this discussion, is we have a benchmark and we have one group of experts telling us that coordinated care, which I would argue gives you much better quality of care, is going to be much more expensive than traditional Medicare, and the other actuaries and experts telling us just the opposite, and I see this benchmark going right between the two.

The question I am going to keep coming back to is, as we go through this discussion in terms of whether or not we vote on this amendment, but as we discussed over the next several days, which approach, what benchmark, will maximize the competition over time?

Regulated competition, controlled competition, but competition that can be sustained. It is unclear to me, and it is unclear, I think, to the experts who have advised us. We will have to make a decision. I would hope that both the Chairman and the Ranking Member, the two managers of this bill, will work very closely with a number of us on both sides of the aisle to achieve that goal.

I am not sure whether or not this is going to come to a vote. If so, I will support the amendment of Senator Kyle at this junction, although I think what would be most useful is to recognize that nobody has the real

answer of what the ideal benchmark should be, that we should get as much data as we can in the next several days, and then optimize the competition that will be part of both the freestanding drug plan as well as the PPO model.

The Chairman. Senator Conrad, then Senator Bingaman.

I should announce that I just got a message that our vote just started. I guess maybe the Senate Majority Leader could think in terms of maybe stacking votes so we do not have to go back and forth.

Senator Frist. Let me address that, Senator, when we go to the floor and see where we are.

The Chairman. Senator Conrad, then Senator Bingaman.

Senator Conrad. Mr. Chairman, I had not intended to speak on this amendment. But I think, maybe in light of what has been said, that it is important for a somewhat different view to be expressed here.

My own strong belief is that the majority opportunity for savings is in coordinated care. You have got 5 percent of the beneficiaries using half of the budget, 10 percent using 65 percent of the budget.

The one big experiment that has been done has got 60,000 patients in it. They have assigned a case manager

to every one of those who are chronically ill and they have reduced the hospitalization rate by 50 percent.

By making certain that there is not a duplication of tests, making certain that prescription drugs are used appropriately, they have found that they have been able to reduce the number of prescriptions by about 50 percent for each of the patients, because there is a lack of coordination. They are going to multiple specialists, going to multiple doctors. Nobody is bringing it all together and watching carefully what is being done.

So my own view is, that is where the big savings are. I had a health care expert meet with me several weeks ago. He has been a hospital administrator, run a big company. He said, Kent, one of the great myths of health care is that competition is going to save money.

He said, I think the experience is that competition costs money. He said, if you have two hospitals in a community, it does not reduce the costs in the community, it increases the cost in the community. Well, that is a debate for another day. But I do believe that the big savings are in this coordinated care area.

The Chairman. Senator Bingaman.

Senator Bingaman. Mr. Chairman, let me just state a concern I have. I may not be understanding Senator Kyl's proposal that well. But I have always thought that it

made sense in deciding what to pay these companies to participate in this to have that decision made with some relationship to what Medicare fee-for-service is now paying, or would be paying in the future.

I mean, we are now talking about adopting a system where you would set the fee that would be paid to the PPOs that wanted to participate, or the HMOs, without any requirement that it relate in any way to the traditional Medicare.

I mean, the mark that the Chairman and the Ranking Member have provided to the committee here guarantees that we will pay more than the fee-for-service rate right now. It says, either fee-for-service or Medicare+Choice, whichever is higher. Am I wrong about that?

Mr. Scully. Senator, that is the cap.

Senator Bingaman. You cannot pay more than that.

Mr. Scully. You cannot pay more than that.

Senator Bingaman. Right. You cannot pay more than that. But at least we are setting the rate that we would pay, or permit to be paid, to these private companies in relation to what would be the cost of providing the service without their participation.

I think what Senator Kyl's proposal does, is to essentially say, no, let us set it on some other basis, on the basis of what the most competitive or the lowest

cost of three private companies is. Let us take the middle of those three, whatever that happens to be, whatever the relationship that has, to the fee-for-service plan under Medicare, so be it. I do not think that makes a lot of sense.

The Chairman. What is your pleasure, Senator Kyl?

Senator Kyl. Mr. Chairman, first, let me just respond to the last two comments. If government wants to set prices, I think most of us know what happens with that. We currently set prices for the providers who provide care under Medicare and we find that routinely we have to go back and adjust those prices. There is a very inelegant term used called "give-backs." But the reality is, it always out of whack. We never can guess right. Everybody is always an extremist as a result of that.

What this says, is that the market should decide. It goes to something that Senator Conrad said. He said the real opportunity for savings here is in this kind of managed care that can take a cohort of patients that may be very sick, and by managing the kind of care provided to them, actually reduce their hospital stays, reduce other expenses, and so on. That is what PPOs do.

So, the opportunity here is to save significantly. It could be that those three bids are well below this amount. In some areas, they undoubtedly will be. In

some areas, they may be more. We are not smart enough to know that. If CBO is right, then we are heading for a disaster here and we need to know that going in. We cannot possibly know for sure.

So it seems to me to make more sense to start out with what had earlier been proposed of the three lowest bids and see what happens. Now, of course, we can always adjust that. But that, to me, is the answer.

Senator Kyl. Mr. Chairman, with respect to what your druthers are, as I said in the beginning, we need to have a little bit better data on this, I think, before we can make a decision.

I think Senator Baucus made the point that it does have to remain within the $400 billion, and of course that is exactly true. With the score from CBO, we will know whether or not this can be accommodated within the $400 billion.

I would just say, I appreciate the opportunity to visit with Senator Bingaman, Senator Conrad, and others who may or may not have a little different point of view, to visit with the administration about this.

Since you and Senator Baucus have assured me that you would continue to work--at least, Mr. Chairman, you indicated--toward this goal if possible, then it would be my suggestion that we not have a vote on this at this

time because we really do not have the data, I think, to make an informed decision. But, when we do, to have an opportunity to discuss that with colleagues and see if we might be able to make a change.

The Chairman. I thank you very much for withdrawing your amendment.

When we return from the vote, we will take up one of Senator Rockefeller's amendments. Then the next Republican amendment would be Senator Nickles'.

Thank you.

[Whereupon, at 3:42 p.m. the meeting was recessed.]

AFTER RECESS

[4:05 p.m.]

The Chairman. Since Senator Rockefeller is not here, we go to Senator Daschle, if you are ready.

Senator Daschle. Mr. Chairman, I am. I am just trying to remember which number it is.

I would offer Amendment #2. We have talked this morning, and I think our committee has had a lot of very good questions, about the volatility, potentially, of the premium. Our staff has done a very good job of clarifying where we have certainty and where we have uncertainty.

We have certainty with regard, basically, the actuarial value of the benefit. That, I think, is probably as good as we are going to get. We have certainty with regard to the deductible. We have certainty with regard, pretty much, to the co-pay because it is part of the actuarial calculation.

We have certainty with regard to the stop-gap. The only place where there is uncertainty is in the area of premiums.

Now, we have established that the national average is going to be $35 to start. There are those who have suggested that it could be lower than that if competition is going to work. I am skeptical, and I think Senator

Conrad's point earlier was right.

But it seems to me, if we have certainty in all of the areas, that we ought to see if we can find a way to address the concern that Senator Snowe addressed, and others have addressed in this discussion so far about the premium.

So what this amendment simply does, is to say, all right, there can be a lot of flexibility. It can be below $35, it can be above $35. At least, let us tell seniors that it really cannot go above 5 percent of the national average. Therefore, you have got certainty in that, too.

So then we can say, in all of the categories where there are variables, there is some degree of flexibility, but not unlimited. I would call attention to a comment I made this morning, a fact that I thought was quite startling.

Right now, with Medicare HMOs offering drug coverage around the country, there are variables that range from $99 in Connecticut to $16 in Florida, and maybe even a wider variance than that. I do not have the complete, State-by-State analysis in front of me. But if it can vary that much, it just seems to me that having some degree of stability from year to year makes sense. That is all we are saying.

The national average, of course, may go up, it may go down. As it goes up or down, this would go with it. But a 5 percent variance on top with no variable below, that is, they can go as low as they want, they just cannot go above that 5 percent, seems to me to make a lot of sense, and that is what the amendment does.

The Chairman. Could I ask either Dr. Fowler or Linda Fishman to give the rationale? We discussed this a little bit in our Q&A, but I would like to have a recitation of it, if I could, at this point. In other words, the committee's position, the mark's position, and in a sense, then, in opposition to Senator Daschle's amendment.

Ms. Fishman. The idea is not to constrain the flexibility of the plans to offer competitive packages in the marketplace.

The Chairman. I think, Mr. Scully, you have stated that this is necessary to get the maximum buy, the maximum benefit to have this sort of flexibility. Is that fair to say?

Mr. Scully. We also think that people are going to offer other benefits that may vary in the benefit structure as well. I think, although we have not scored it, but I think CBO actually scored this, I thought, as potentially raising the premium above $35 by raising the

actuarial cost. Am I right?

Mr. Holtz-Eakin. We have not scored this specific amendment.

Mr. Scully. All right. I understand Senator Daschle's point and concern about coming up with a consistent national premium. We actually had a consistent national premium in the PPO nationwide in our plan and the committee has gone off on a slightly different track.

But I think, on the stand-alone drug benefit, there is a different structure and it is much more difficult to do that and is probably going to cause problems with the structure of the benefit package. I think putting a cap on it at 5 percent just above the national average is something we are not comfortable with the design of, to be honest.

Senator Daschle. Mr. Chairman, I am a little confused on that issue because we talked this morning. My very first question was one relating to the benefit, and the answer I thought I got was that, within the actuarial confines, there is a requirement that the benefit structure is the same, it is comparable.

But, Tom, you are saying that because the benefit is going to vary so much, you are going to have to have a comparable variance in the premium?

Mr. Scully. No. I think the concern I have, Senator, is let us say, hypothetically, in the region that includes North and South Dakota, Montana, you had two plans that bid and you had actually the same package they had to provide.

But let us say some plans decided to come up with a tougher formulary and basically try to drive down costs to drive down premiums to get more market share, which they may well do.

You are constraining the ability to have them have differential benefits, differential formularies to within, basically, 5 percent of the national mean. You may get significantly different benefits packages.

I might go out and try to drive down the premium and come up with a really tough formulary if I was in a plan, come up with a really cheap package, and say to beneficiaries, here is the package, but we are only going to pay for three statins instead of 10.

I am sure people may not like that, but that is very viable and they have a much lower cost. So, constraining the whole range of premiums to just 5 percent could be difficult, I think.

Senator Daschle. We established, Mr. Chairman, I thought, that there had to be comparability in the benefits, that there was not a lot of variation from one

benefit structure and one plan to another in order to accommodate the actuarial consistency that we are seeking as an intent of the bill.

So it seems to me, if the actuarial consistency on the benefit side is there, there ought to be a consistency on the premium side as well.

Now, what we are saying is, we recognize they cannot be identical. We are already taking the national average as the base, so the national average could go up or down based on whatever the circumstances may be and they will change from year to year.

We are just saying you can go down as far as you want, you just cannot go above 5 percent, because we have a consistent benefit, we have a consistent co-pay, we have a consistent stop-loss, we have a consistent deductible. Why not make it a reasonably consistent, although not identical, premium?

Mr. Scully. Senator, if I could just jump in again. I think the concern we have, is you have to have at least the basic actuarial benefit. But I believe--I have not read it, the bill has changed a little bit--you have to have at least a certain number of drugs in each therapeutic area, but the benefits can vary pretty dramatically.

We certainly hope some people are going to come up

with cheaper benefits to save beneficiaries' costs. If they can only go in any area, 5 percent from the mean, I think that will limit that.

I think Senator Snowe, and I forget who the other Senator was, Senator Lincoln, I think, proposed an amendment which they may offer later which we talked about this morning to give the Secretary the ability to have geographic adjustments and take volume into place and try to come up with the most consistent premiums. I think we would be a lot more comfortable with having the flexibility rather than a hard cap like 5 percent.

Senator Daschle. Well, Tom, you just said something that I guess we really need to establish some clarity on. You just said the benefits could vary dramatically. If they could vary dramatically, then all that we talked about this morning is factually inaccurate.

Mr. Scully. Not the benefits, as far as the deductibles and the gaps.

Senator Daschle. No, I know that. I am talking about the benefits. But I asked the question this morning, and I thought Dr. Fowler did a very good job of giving me an answer, which was that there would be some variance, but we were going to guarantee structural integrity and uniformity within that actuarial balance or within that actuarial value all across the country.

But now Tom says that we are going to vary dramatically, potentially. Could you address that?

Dr. Fowler. We actually do not believe that they will vary that much. But I think one of the key points, and I think it was either Doug Holtz-Eakin or Steve Lieberman who pointed out that the deductible was $275, it could not go above that, but it might be able to go lower. So, you might expect plans to offer more benefits and charge a higher premium.

So I think what the argument would be, is that the benefit that is described here is fairly standard, but the variation you might see is if a plan decided to offer more benefits and charge a higher premium.

I suppose the argument against limiting it or putting a cap on it is just that you would be constraining beneficiaries from potentially getting more out of those plans.

Senator Daschle. But, see, I thought the basic protection in the bill was that we were not going to vary the benefits, because you could actually have an insurance company who says, I am going to provide the same benefits for a higher premium in a certain area, and I thought we were attempting to avoid this same benefit/higher premium rather than higher benefits/higher premium by requiring an actuarial uniformity within the

benefit structure.

Dr. Fowler. Right. I think there would be constraint on the actuarial minimum, but I do not know that there are constraints on going beyond the actuarial minimum, in which case maybe you would offer a $100 deductible, and the premium would reflect that.

Senator Baucus. Let me ask you, too, just a point of clarification. So you are saying the deductible, under the mark, can go down.

Dr. Fowler. I think that is what CBO had said. Is that correct?

Senator Baucus. Yes. Now, the next question is on the co-pay. Can the co-pay fluctuate in addition to the premium?

Mr. Holtz-Eakin. Yes, the average co-pays can fluctuate, to my understanding, but there are other constraints. As John Blum said this morning, there is a constraint.

Senator Baucus. I understand. I understand. Right. I am just trying to make sure we have our facts straight here, the degree to which not only premiums, but deductibles, can go down. Frankly, I am agreeing with the nature and thrust of the argument by the Senator from South Dakota, that people are concerned about the premiums.

But in order to solve the problem, to the degree there is one, it is helpful to know what the facts are. If the deductible could not go down, that is going to have some effect potentially on premiums. I am asking, next, is the co-pay set, fixed in plans? Can that also moderate, a little, one or the other up or down?

Mr. Holtz-Eakin. I would think of this as a balloon; one can squeeze it in different ways and shape it. But, in general, our assumption would be that plans would want to avoid benefits that would attract sicker people, people who tend to be more expensive.

So if all plans had the same degree of flexibility, their first take would be, as the market worked through its competitive process, to offer benefits that would tend to be more front end-loaded, which would be attractive to people who had lower drug spending, within the constraints of the actuarial equivalent.

But, if I could, Senator, going back to Leader Daschle's question, I think there are two different kinds of variation. One, is within a region. If one had three plans or five plans that were offering identical benefits but they might have differences in efficiency, that would be a within-region basis for having the variation in premium. A cheaper plan would have a lower premium.

There is another form of variation that might occur

which is across region. So, part of what is confusing here, is you have both those forms of variation in this.

Senator Baucus. I think you are wrong. I did the same thing. Last night, I actually read part of the mark. As I vaguely remember through the fog, within regions, there cannot be variation.

Mr. Holtz-Eakin. I am sorry, Senator. There cannot be variation within a specific plan's premium. But part of the competitive dynamic is, if there are three plans and the first plan charges a $35 premium, the second plan charges a $32 premium, and the third plan charges a $38 premium, that they would average $35 in that case.

They would be the same throughout the entire region. But beneficiaries would look at that and decide whether they wanted to go to the plan that had the lowest premium or not.

Senator Baucus. If I might, what is the strongest argument any of you six can come up with that backs up the general assertion that there will be volatility in premium, which is the main concern I wanted to ask? I would just like to know from one of you. I do not care about all six, just one of you.

Mr. Scully. I was not arguing that the benefit would vary a lot. I am saying, if I were in the business, I think one of the things you are going to see,

is I believe the bill is structured to guarantee access of every drug, in a category, at least, that is available.

There are many of these drug plans that all of us have that may have different co-payments or deductibles for different types of statins or different types of gastroenterological drugs. Those are the top two selling drugs in the country.

They may say we are going to have a higher co-payment for Nexium, or a higher one for Lipitor, and they control their costs by that. Some folks do not like that much, but that will vary the premium.

If you say, hypothetically, you only had two plans in a region, and you only had 20 nationally, if somebody came up with a really low premium, that would drag the national average down. If you said nobody could charge more than 5 percent of that, you are going to basic limit the cap to 5 percent of the national medium.

If you have one or two plans that came up with really cheap plans, you are really going to throw the balance off of the others. Limiting, theoretically, 20 plans to having a premium within 5 percent of the mean is going to be difficult.

The Chairman. I would like to have Senator Hatch and Senator Breaux comment on this.

Senator Hatch. Let me see if I can ask a couple of questions or answer a couple of things with regard to the distinguished Leader's suggestion and amendment.

As I view his amendment, it takes away from the basic premise of our bill. We are saying, let the market work. We want to give seniors the same coverage choices, private insurance options included, that those under 65 have. Why should the seniors not have that benefit, too?

So there is a basic plan, but that does not mean they cannot offer additional plans where the premium may vary. Is that right? Is that what I am saying? Is that not correct, what you are saying?

Mr. Blum. Senator, I think the policy would be that, under the Chairman's mark, all plan have to offer the standard benefit. There could be some variation.

Senator Hatch. But they can vary the plan and they can charge differently for it if the people are willing to pay for it. If they are willing to pay for it, they get the additional benefits, but the basic plan is there for the basic amount. Is that correct?

Mr. Blum. Yes, that is correct.

Senator Daschle. Could I clarify, though? Here is my concern. We cannot get HMOs and PPOs to come to South or North Dakota. I mean, they just do not want to come, for a lot of reasons. Administrative costs are high. I

mean, we have tried. So my concern is, you have got a national average of, say, $35.

And while we are saying, all right, what is it going to take for you to come in there, the beneficiary is going to say--if history is any guide, and you have $99 now in Connecticut and $16 in Florida--they are going to say, well, look, the only way this is going to work is if we charge the beneficiary $70 a month. It sounds to me as if there is no limit to what those plans can cost the beneficiary in terms of a premium.

Now, up until just a few minutes ago, I thought that there was a standard deductible, and a standard stop-loss, and a standard co-pay, but even that can be varied. So the more variables there are, the more complexity there is going to be in this whole system.

All I am saying is, you can vary, but why, in a rural State where it is already very, very difficult to get a PPO to come to our State, would you say, look, charge whatever it takes?

Senator Hatch. Because it is better than what they have now.

Senator Daschle. No, it is not better.

Senator Hatch. Yes, it is. It is a voluntary program that they can have various choices in. It is better than what they have got now under Medicaid and

Medicare.

The Chairman. Senator Breaux? The Chair recognizes Senator Breaux.

Senator Breaux. Thank you, Mr. Chairman.

I appreciate very much what my Leader is attempting to do, and that is to come up with a stable and dependable premium so people will know what the cost is going to be.

The concern is, if you have a private sector delivery system and you tell them to compete both on quality and price, the more we fix in the legislation what the price is going to be, the less competition there will be.

What we have done so far is to drastically restrict competition by saying the deductible cannot go higher than $275, that the co-payment is going to be limited to around a 50 percent co-payment with a lot of restrictions, and that the catastrophic kicks in at $5,813 total payment. So, we have really restricted what they can compete on by spelling out that these are fairly locked in legislatively.

Well, on the 50 percent co-payment, are there not additional restrictions about how that can be adjusted one way or the other on the co-pay?

Mr. Hayes. The benefit package has to be actuarially equivalent using the FEHBP standard, so they

could vary cost sharing for preferred drugs/non-preferred drugs in a way to contain costs to make the package affordable, but they would still have to meet the standards for equivalency.

Senator Breaux. All right. My point is, under the Leader's amendment, 5 percent of $35 would be $1.75, I take it. So the premium could only go up to, I guess, $36.75 under that restriction if $35 is the standard. I am just concerned that, the more we limit the ability for flexibility, the less competition we are going to get.

The safeguard and the protection here, is that any of these premiums or any of these co-payments or deductibles have to be approved by the Administrator. If someone comes in with a premium that is out of whack with the benefits, the Administrator is required to not approve that offering because it is not equivalent to what the standard package has.

I mean, the Administrator, the bill says, could not approve a plan unless the premium for both standard coverage and any additional benefits accurately reflected the actuarial value of the benefits. I think that that is the way the protection is provided for consumers.

My concern, is that the more we lock into law exactly what the price, and the deductibles, and the co-payments have to be, the less competition there will be because of

the inability to vary any of these things.

I think we ought to say that the Administrator can make sure that they are actuarially equivalent. If someone comes in with something off base, then it is not going to be approved to be offered. That is the concern that I have with fixing it in.

If we fix it in, you know that every year we are going to be back here, just like we did today, with a whole series of amendments to lower the premium, lower the deductible, or increase the co-pay, or what have you, and we are going to be right where we are in terms of fixing the price. I mean, those are my concerns.

The Chairman. I wonder if we could vote after Senator Conrad gets done with his comments.

Senator Conrad?

Senator Conrad. Thank you, Mr. Chairman.

I have just been struggling to understand how this formula actually works. My staff explains it to me in this way. If you have a national weighted benefit value of $100 and you have a benefit premium of $35, but the plan in your area has a benefit value of $110, the premium does not go up proportionately. It does not go up 10 percent. It goes up by the dollar value of the difference. It goes up $10.

So instead of having a premium of $35, you have a

premium of $45. So, in other words, if the national weighted benefit value is $100, and in your area it goes up 10 percent, the premium does not go up 10 percent, the premium goes up 30 percent.

I think this is, in a way, what Senator Daschle is trying to get at. It is because of the structure of the formula that you get that disproportional difference. Is that an accurate description of how it works?

Dr. Fowler. Well, as I look to my left, everyone seems to be shaking their heads.

Senator Conrad. Yes or no?

Dr. Fowler. They are shaking their head yes. I cannot say, myself.

Senator Conrad. Well, maybe somebody that understands how these formulas work can tell me if that is a correct characterization of how it would function.

Mr. Holtz-Eakin. Yes, Senator, that is. The plan is designed so that--to try not to get into economists' jargon--there are very strong price signals, which translates into saying if your plan is $10 more than the benchmark plan, the beneficiary sees all of that.

Senator Daschle. Sees all of it. You mean, pays all of that?

Mr. Holtz-Eakin. Pays all of that. Yes. Sorry, Senator. Similarly, if your plan is $10 cheaper, the

beneficiary would see $7.50 of that.

Senator Conrad. That is based on this 2570.

Mr. Holtz-Eakin. If it is $10 cheaper, the beneficiary would, in fact, have a $10 lower premium.

Senator Conrad. $7.50.

Mr. Holtz-Eakin. No, it is the full $10.

Mr. Scully. It is only the PPO side.

Mr. Holtz-Eakin. I am sorry, I misspoke. I was confused as to where the specification was. We have been going back and forth on it.

The Chairman. Would Senator Daschle like to close the debate?

Senator Daschle. Well, Mr. Chairman, I guess I would simply say that Senator Conrad's question just hit the bull's eye. We are talking about benefit delivery in rural States that could be a lot more expensive if we are going to entice PPOs to come there.

What we are saying, is that the beneficiary is going to eat the cost on a nominal dollar value increase for whatever it takes to bring them there. Now, I agree with Senator Breaux, the Secretary does have some authority here. But if the Secretary says, look, what else can I do?

The law says I have got to get two people to come out there. So, it is a very, very significant cost increase

if we are talking about, not $1.76, but we are talking in this case of roughly a 30 percent increase on just a $10 increase on the nominal value of the policy itself.

So, it just goes to my point. I would say, at least for the first couple of years, we ought to say, look, as this thing sorts out, let us not force the beneficiary to eat all these increases in cost.

If there is going to be competition, let them fight it out and bring them down, if possible. But at no point should it go above the national average by more than 5 percent. That is the last word.

The Chairman. Would the Senator like to have a roll call vote?

Senator Daschle. I would.

The Chairman. Would the Clerk call the roll?

The Clerk. Mr. Hatch?

Senator Hatch. No.

The Clerk. Mr. Nickles?

Senator Nickles. No.

The Clerk. Mr. Lott?

The Chairman. No, by proxy.

The Clerk. Ms. Snowe?

Senator Snowe. No.

The Clerk. Mr. Kyl?

Senator Kyl. No.

The Clerk. Mr. Thomas?
The Chairman. No, by proxy.
The Clerk. Mr. Santorum?
Senator Santorum. No.
The Clerk. Mr. Frist?
Senator Frist. No.
The Clerk. Mr. Smith?
The Chairman. No, by proxy.
The Clerk. Mr. Bunning?
Senator Bunning. No.
The Clerk. Mr. Baucus?
Senator Baucus. No.
The Clerk. Mr. Rockefeller?
Senator Rockefeller. Aye.
The Clerk. Mr. Daschle?
Senator Daschle. Aye.
The Clerk. Mr. Breaux?
Senator Breaux. No.
The Clerk. Mr. Conrad?
Senator Conrad. Aye.
The Clerk. Mr. Graham?
Senator Baucus. Aye, by proxy.
The Clerk. Mr. Jeffords?
Senator Baucus. No, by proxy.
The Clerk. Mr. Bingaman?

Senator Bingaman. Aye.

The Clerk. Mr. Kerry?

Senator Baucus. Aye, by proxy.

The Clerk. Mrs. Lincoln?

Senator Lincoln. Aye.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. Mr. Chairman, the tally is 7 ayes, 14 nays.

The Chairman. Accordingly, the Daschle amendment is defeated.

I now go to Senator Nickles.

Senator Nickles. Mr. Chairman, thank you very much. I have a couple of questions to ask staff in conjunction. I think we can deal with several amendments. Maybe you will accept them all by voice. [Laughter].

One of which, is Senator Kyl had an amendment that said, on PPOs, we should use competitive bidding. He mentioned it for all of them. Both you and Senator Baucus indicated a real desire to see the PPO model work. I would just offer a suggestion. I think Senator Kyl and I also have it listed as an amendment.

But one constructive, positive alternative or compromise would be to at least have 5 of the 10, or half of the areas designated, be on a competitive model. Then

we would give both a test for two or three years and find out how it works. I would hope that that would also be considered. You mentioned you would consider the competitive alternative. I would just mention that as a possible compromise.

Senator Baucus. Which amendment? Sorry, Senator.

Senator Nickles. This is a suggestion.

Senator Baucus. Is it listed here?

Senator Nickles. No. It is actually the Kyl-Nickles amendment. It is one that we were planning on doing. It was on competitive bidding, saying where Senator Kyl had an amendment, all of them should be competitive bidding. I am suggesting a compromise.

It would be another amendment that we have, while you are reviewing it, that we might consider as a viable, constructive alternative is to have half the districts in competitive bidding. It is not my intention to push it for a vote, but something I hope that would be considered by members.

The Chairman. I think it is fair, under what Senator Baucus and I told Senator Kyl, that that can be considered on the table.

Senator Nickles. I appreciate that.

Mr. Chairman, just let me ask you. I asked staff during the walk-through, on cancer, when we made a

reduction in the payments on certain oncology drugs, staff mentioned that there were some changes made on reimbursements to physicians.

I have an amendment dealing with that. I have not really reviewed what staff has included in the Chairman's mark. I have language that deals with it. I do not know exactly what the differences are. Would staff care to maybe bring me up to date? Are they close to the same or is there a lot of difference?

Ms. Fishman. I am not familiar with the proposal that you have put forth. I can tell you what is in the mark.

Senator Nickles. Just very briefly, because I have about four things I want to go over real quickly.

Ms. Fishman. The mark would establish a practice expense relative value for the fee schedule next year using survey data that has been collected from the physician specialty organization, the oncologists. If the data covers the practice expenses for oncology administration and services, it meets the Secretary's criteria for those acceptable survey data.

Senator Nickles. So it would actually change the reimbursements, or studies it?

Ms. Fishman. It would use the data submitted by the physician specialty group to adjust their payments to

cover the losses they would incur as a result of changing the prices for those oncology drugs.

Senator Nickles. Mr. Chairman, I will withhold. You have not reviewed our amendment?

Ms. Fishman. No.

Senator Nickles. I will withhold that amendment for the time being. I will review what is in the Chairman's mark, and I would hope staff would take a look at this.

The Chairman. I think I can speak for what is in the Chairman's mark. I do not think you would be entirely satisfied with what is in the mark. Because we had to move ahead, the way we are now, I have made some commitment over the next three or four days to sit down and visit with people from the oncology community and try to satisfy them that the process we have for HHS would be satisfactory to them.

I think there is basic agreement on everything here. It is just a matter of making sure that what we intend to do for the people that do the therapy, is that they are going to be adequately compensated in a way that recognizes their professional value.

Now, here is the situation. The situation is, presently, everybody agrees that we are reimbursing at a very high level for the drug and the service is paid for out of the higher level that we pay for the drug. So,

common sense dictates that we give a reasonable reimbursement for the drug, on the one hand, and pay the professional people a reasonable fee on the other hand. I think it is just a matter of satisfying people that that is what our goal is.

Senator Nickles. Mr. Chairman, I appreciate that. I appreciate your willingness to meet with interested parties to make sure that we come up with something appropriate. And I am not sure exactly if that is the language that I have, or the language that is in the Chairman's mark, or what we might work up, but I appreciate your attention to it.

Mr. Chairman, I have two or three amendments. Let me just touch on them very quickly, one of which I mentioned before. We have always said that when we were going to do Medicare changes----

Senator Baucus. I thought we were doing one by one here, back and forth.

The Chairman. We really wanted to take one amendment.

Senator Nickles. All right. I will do my S-CHIP amendment. I was going to withdraw the other two amendments. Maybe I will push them for a vote.

I have two amendments. One is the eligibility age. I will just notify colleagues that I think we should do

that. I think we should have concurrent eligibility age for Medicare and Social Security. I am not going to offer it now.

I also will tell you I think we should have reimbursement co-pays at 10 percent, just like we do on the card at 10 percent. I think we should do that for the program. I will not offer those.

The one I will offer, is the amendment to strike the S-CHIP expansion. It belongs in the TANF bill. It does not belong in the Medicare bill.

We are going to mark up TANF. There was an amendment added, I guess last night, to expand S-CHIP to include legal non-residents in S-CHIP, giving them a higher reimbursement than Medicaid eligibles. I find that offensive.

I think it is a mistake. I think it is something we will debate, and should debate, when we deal with the welfare bill or when we deal with the TANF bill that we are going to pass later.

But to put it in a Medicare bill, it does not belong here and it is bad policy. Why in the world would we, would Congress, have a higher federal subsidy for individuals that come into the country legally after signing a document that says they will not become a ward of the government for five years, they will not become

dependent on the government, they will not be asking for governmental assistance for five years?

They have sponsors. Why would we say, no, we will take care of that expense for having babies and/or for the children? That is not current law. It is an expansion of entitlement. It is subsidized at a rate from the Federal Government 30 percent higher than Medicaid.

So, we are subsidizing legal non-resident aliens higher than we subsidize U.S. citizens. I do not think that is good policy, but I really think it should be vetted and discussed outside this bill. This is a Medicare bill.

If we are going to do a welfare bill, let us do a welfare bill. If we are going to do TANF, let us do TANF. We have to do it. It expires by June 1. Expansion on this bill is inappropriate. Very inappropriate.

It is disguised by saying, well, we are just going to do it for a couple of years. We are changing immigration policy, we are changing welfare policy. We are rewriting the welfare bill. It is not well thought out, in my opinion.

So, Mr. Chairman, I have an amendment to strike whatever section was added on.

The Chairman. I will be very candid with the Senator from Oklahoma and not say he does not have a good point, but in the spirit of bipartisanship, as we were going through the amendments, I found a lot of people on my side of the aisle had some amendments that had merit and should be adopted.

When we adopted one amendment on the Republican side, in the spirit of bipartisanship, we considered an amendment on the Democrat side. I can say to the Senator from Oklahoma, the Republican amendment was much more expensive than this amendment was.

Even though I have to agree with you that TANF might be a better place for doing this, I have made an agreement and I am going to stay with that agreement. I would like to have my colleagues leave this in the mark.

Senator Lincoln. Mr. Chairman?

Senator Bingaman. Mr. Chairman?

The Chairman. Who is requesting the floor? Senator Bingaman?

Senator Bingaman. Well, Mr. Chairman, let me just say I support your decision. I think this is very good policy and I think it should be in this mark. I think it was dealt with in TANF as a way to pay a bill. I mean, when welfare was revised, some of these benefits were dropped.

The policy of this administration, as I understand it right now, is that, first of all, a State can provide medical care to children of legal immigrants and to pregnant women. The question, though, is are they going to have to pay 100 percent of it or is the Federal Government going to participate?

In my view, immigration is an issue that is solely in the control of the Federal Government. States have very little ability to affect who immigrates into the country and who does not. The Federal Government has a legitimate responsibility to participate in providing services to people that they decide should be allowed to immigrate. We are talking here about legal immigrants.

Now, current policy, as I understand it, of the administration is to provide health care to the unborn children of undocumented illegal immigrants into the country.

Now, if we are providing health care to unborn children of undocumented workers, why would we not provide health care to born children of documented workers and immigrants into the country? So, I think that this is a very good policy that you have here in this provision and I strongly support your decision to keep it in the mark.

The Chairman. Would the Senator like to have a roll

call vote? Well, I forgot Senator Lincoln. Then I will get you for closing remarks. All right. We will get whoever wants to talk.

Senator Lincoln, then Senator Nickles, then Senator Santorum, then Senator Frist, then Senator Hatch.

Senator Lincoln. Thank you, Mr. Chairman.

Mr. Chairman, I would just like to respectfully disagree with my colleague from Oklahoma. I think giving the States the flexibility here to be able to provide an option in lifting the restrictions on health insurance coverage for legal immigrant children and pregnant women, giving them the option to provide it through both Medicaid and S-CHIP, I think is absolutely essential.

We have heard from our States on multitudes of occasions, coming from a State like Arkansas where we have seen, as a percentage of our population, the largest increase in Hispanics over a 10-year period of time.

I would just like to remind my colleagues that we have talked today about chronic care, we have talked about preventive care, we have talked about how cost effective it is.

Well, providing pregnant women the medical care that they need during their pregnancy is a win-win for both the quality of life for children that we are bringing into this world as well as economics, because we know for

every dollar we spend in prenatal care, we save $4 down the road.

I would also like to remind my colleagues that when these illegal women give birth, their children are legal residents and they are covered, which means if we do not give them the prenatal care, they certainly run the risk of presenting us with multitudes of more serious problems like learning disabilities, low birth weight, which causes much more in terms of health complications that are much more costly to Medicaid, or to whatever program. We are going to find ourselves dealing with that.

So if you are looking at it from the human standpoint, if you are looking at it from the economic standpoint, for the cost of this package, which I think is $35 million, it is a good investment in the health care of the people of this country.

I would just encourage my colleagues to take whichever point they would like, but certainly look that there are two sides to this story in terms of quality of life, as well as economics. For us to move forward in this at this juncture, I think, is absolutely appropriate and I encourage my colleagues to vote against the gentleman's amendment to strike it.

The Chairman. Senator Santorum?

Senator Santorum. Actually, I will let the Leader

go first.

The Chairman. Senator Frist?

Senator Frist. Mr. Chairman, I will be very brief.

As we opened this morning, I said that my goal in this bill is to improve health care security for seniors. We are debating the Medicare program, our program that is for seniors and individuals with disabilities.

The large health care issues that we have to come back and address in this committee, the whole issue surrounding Medicaid that at some point we need to address, the uninsured that we need to address, all are good issues and important issues for us to exercise our jurisdiction over.

But this bill, this $400 billion expansion of this entitlement program for our seniors, is what we are talking about today. My understanding of the provision is that it expands the Medicaid program and the Children's Health Insurance Program, S-CHIP, to a new population. We can argue that and we can debate it, but it is on the Medicare bill.

Although I have not studied the particular issue at all, I see that States have the option to include coverage for legal immigrants. They have to pay for, yes, the entire cost of coverage.

You look at the Medicaid implications for it, and I

think we could even look for ways to include coverage to needy families at some point, but we are talking about Medicare health care security for our seniors.

Those legally in this country who are poor certainly deserve some assistance, but I do not think that this Medicare modernization bill is the proper place to debate this expansion. It is a bill about helping seniors, helping seniors get access to prescription drugs and improved benefits.

It is to help individuals with disabilities gain better access to modern health care through Medicare and not Medicaid. Thus, I wish to support the amendment by the Senator from Oklahoma in removing this from the bill.

Senator Lincoln. Mr. Chairman, may I ask a question?

The Chairman. All right. I will take the question, but I would like to then go to Senator Baucus. All right. I thought you said you were----

Senator Santorum. I was just yielding to him to let him go first.

The Chairman. Go ahead with your question. We will get everybody in. We can stay here all night.

Senator Lincoln. May I ask my question?

The Chairman. Yes.

Senator Lincoln. It was just an issue that Senator

Frist brought up. That is, if these children are born in this country and become legal residents and are disabled, then they are covered under Medicare. Is that not correct?

Ms. Kegler. Medicaid.

Senator Lincoln. I thought that Medicare did cover disabilities.

Ms. Kegler. Not in that case. They would be covered under the Children's Medicaid program through a disabled eligibility pathway, disability.

Senator Lincoln. All right. Thanks, Mr. Chairman.

The Chairman. Senator Santorum?

Senator Santorum. Yes. Mr. Chairman, I would just say a couple of things.

First, in response to Senator Bingaman, there were a lot of reductions in benefits to legal immigrants, and many of us around this table were involved in them because we were being overrun at the time with the enormous growing costs of the legal immigrant population accessing welfare benefits, including this benefit.

We have subsequently judiciously looked and re-looked at some of those reductions and have restored benefits in areas where we may have cut a broader swath. This may be one such area.

But I would argue that we had a very full and lengthy

discussion in the last welfare bill. We should have another one with respect to the benefits for legal immigrants in the next welfare bill when you are talking about lower income individuals in the context of how we are going to fit it into the reauthorization of that bill.

But to add it to a Medicare bill, I want to associate my remarks with the Leader that it does not belong here. You say it is only $35 million. Well, I can tell you, I have got a whole laundry list of amendments here of $35 million for improvements to the Medicare program that can help lots of seniors, and that is what we are here to do.

We will have another debate and we can put $35 million in to the TANF reauthorization for this, and I very well may support it. I think it has some merit, to be honest with you.

I am not too sure it merits subsidizing it more than we subsidize others, if the Senator from Oklahoma is correct that the level of subsidy here is higher than it would be for even lower income individuals who are citizens in this country.

If that is the case, then I may have a problem with it, but I would be willing to look at ways that we can deal with this issue. But it does not belong here and we need to focus on what we came here to do, which is to

take care of seniors and improve the Medicare system.

The Chairman. Senator Baucus?

Senator Baucus. This is kind of an interesting discussion. First of all, this is not a welfare issue at all. This is a health care issue. This has nothing to do with welfare, zero, zip, nullity.

We are talking about women, we are talking about children who are low income, who are legally in the United States, but who do not receive any help in health care bills under Medicaid simply because they have not been living in the United States for five years. That is all we are talking about here.

It just seems to me if the women and children are legally in the United States--we are not talking about undocumented aliens--and if the State, in its option, decides it wants to provide Medicaid benefits for low income women and children, at the very least, they should be able to do so, and that should be the policy that we should adopt. That is what is in the underlying provision of this bill.

Again, this is a health care issue. This is not welfare. It has nothing to do with welfare. This is just a health care issue.

These are real people, folks. I mean, these are women and children who are legally in the United States,

but just cannot get the Medicaid benefits, even though they are here legally, because they have not been here for five years.

Now, that does not make any sense to me. If they are here legally and are low income, at the very least, it just seems to me that, at the States' option, if States wanted to provide these benefits, we should not stand in the way and we should provide that. So I, therefore, am not in favor of the amendment.

The Chairman. Senator Nickles?

Senator Nickles. Mr. Chairman, I was taking from Senator Baucus' remarks he might be inclined to not be in favor of the amendment. Let me just get a clarification from staff on two things. One, the cost of the amendment. I think Senator Lincoln said it is $35 million. How much is it?

Ms. Kegler. We have approximated that it is $350 million.

Senator Nickles. Over what period of time?

Ms. Kegler. For the three years.

Senator Nickles. Three years. So if it is over 10 years, it would be $1 billion, plus.

Ms. Kegler. Right. But the provision specifically states the three years because the S-CHIP program needs to be reauthorized in 2007.

Senator Nickles. Yes. All right. A couple of comments. So if it costs $350 million over three years, it is going to be $1 billion over 10 if you assume that it is continued. Medicaid is compounding. Last year, it compounded, if my memory serves me correctly, at 13.3 percent.

One other comment. Why in the world would we have reimbursements at 30 percent higher from the Federal Government?

Mr. Scully, does the administration have a position on this proposal?

Mr. Scully. I would also add, Senator, in addition to the S-CHIP score, it probably almost certainly has a Medicaid score that is permanent.

Ms. Kegler. Yes. Actually, the bill has been scored over 10 years, and I believe the score is $2.24 billion.

Senator Nickles. It is $2.24 billion. So it has grown a little bit from $35 million. Now it is $2.24 billion over 10 years.

Mr. Scully. It does have a Medicaid permanent impact and the administration, with all due respect, would be siding with your amendment to take this out, for a variety of reasons, including the fact that we believe that when people sponsor a legal immigrant, the

commitment is to provide health benefits for them for five years.

The concern is that if you bring over a legal immigrant immediately, your mother, or whoever else with no assets, you immediately put them on Medicaid, and obviously the understanding of the immigration law currently is that there is a sponsor who supports them for five years. That is the principle of the current immigration law.

Senator Nickles. Mr. Scully, thank you very much.

I think this is serious damage. You just mentioned, there is a five-year commitment from the sponsors that these individuals coming into the country, they want to enter the country legally, and they sign a commitment they are not going to become wards of the government.

We are basically saying, no, no, we will go ahead and do this. Not only will we take care of it, we will do it a ratio much greater than we do our lowest income citizens. I find that to be absurd. I only find it to be possible because people are making deals without thinking about it. This is not good policy.

This belongs on the TANF bill. This is where it belongs. We are going to mark up TANF this year. We are going to pass an extension, probably within the next week or so, and we need to do TANF and we need to consider

this on its merits. I would urge our colleagues to support the amendment.

The Chairman. Do you want a roll call vote?

Senator Nickles. I do.

The Chairman. Would the Clerk call the roll?

The Clerk. Mr. Hatch?

The Chairman. Yes, by proxy.

The Clerk. Mr. Nickles?

Senator Nickles. Aye.

The Clerk. Mr. Lott?

The Chairman. Yes, by proxy.

Senator Snowe. No.

The Clerk. Mr. Kyl?

Senator Kyl. Aye.

The Clerk. Mr. Thomas?

Senator Thomas. Aye.

The Clerk. Mr. Santorum?

Senator Santorum. Aye.

The Clerk. Mr. Frist?

Senator Frist. Aye.

The Clerk. Mr. Smith?

The Chairman. No, by proxy.

The Clerk. Mr. Bunning?

Senator Bunning. Aye.

The Clerk. Mr. Baucus?
Senator Baucus. No.
The Clerk. Mr. Rockefeller?
Senator Rockefeller. No.
The Clerk. Mr. Daschle?
Senator Daschle. No.
The Clerk. Mr. Breaux?
Senator Breaux. No.
The Clerk. Mr. Conrad?
Senator Conrad. No.
The Clerk. Mr. Graham?
Senator Baucus. No, by proxy.
The Clerk. Mr. Jeffords?
Senator Baucus. No, by proxy.
The Clerk. Mr. Bingaman?
Senator Bingaman. No.
The Clerk. Mr. Kerry?
Senator Baucus. No, by proxy.
The Clerk. Mrs. Lincoln?
Senator Lincoln. No.
The Clerk. Mr. Chairman?
The Chairman. No.
The Clerk. Mr. Chairman, the tally is 8 ayes, 13 nays.
The Chairman. Accordingly, the amendment is

defeated.

Senator Rockefeller?

Senator Rockefeller. Mr. Chairman, my Amendment #1 is the following. Under the Chairman's mark, the only way a senior can get a Medicare-guaranteed standard benefit with a national premium that does not differ from area to area is if private insurers do not enter--do not enter--an area.

I think that is wrong. I think seniors should have the choice of a standard benefit guaranteed by Medicare with a premium they can count on regardless of whether private insurers choose to enter the program or not.

Now, this amendment would provide that guarantee. But I want to make very clear, it does not preclude private insurers from getting into this and participating in the program. It simply makes the choice of the Medicare guaranteed standard benefit available to all.

Now, private insurers can offer a benefit and they can compete for beneficiaries. That is what they say they are in the business of. That is the free enterprise system at work.

One can argue about their cost of doing business, et cetera, but that is what they want, they want to compete for this. That is what we should be wanting them to do, to compete and produce better product at a lower cost if

they can do that.

I do not think that private insurers are more effective. I do not think they are more efficient. I think Medicare is more efficient administratively. They do not have the marketing costs, they do not have to show profit, as do private insurers. I have nothing against private insurers. I am, again, for having them participate in all of this.

I believe this amendment improves the mark by allowing private insurers to participate in the program which most people here are committed to, and providing seniors something that I would really hope we would accept, the option of a Medicare-guaranteed benefit with a standard benefit and a national premium all at the same time.

The Chairman. Let me explain to the Senator why I cannot accept his amendment. First of all, I have to say that I share some appreciation of your efforts to ensure that all seniors have a guaranteed access to prescription drugs, because this is something I dealt with during my work on the tripartisan bill.

Since we have been working on this legislation this year, I have been working with my colleagues on both sides of the aisle on a policy that ensures that, where private plans fail to show up, that we are going to have

what we call a back-up plan. In other words, the government is going to help make sure that we have got ample competition and everybody is going to be served.

So, I hope you know that I am not unsympathetic to making sure that we have got drugs available for everybody, everywhere, any time. I am committed, though, to giving private plans a chance. I think your amendment would eliminate that chance.

I believe, that to maximize competition and all the quality, innovation, and cost controls that come from that, you have got to create a level playing field. So, our policy is to have the government step in only where the competitive environment has failed to flourish.

The Congressional Budget Office--and this is very important--has told us that keeping a government plan going at all times will diminish and hurt our score. In fact, if there was anything unique about the tripartisan plan compared to what we had in all the other plans last year, was where there was competition. That is what kept down the cost of the program and made it fit in within the budget score that we had.

So, our policy is to strike the right balance between fostering competition and providing a government fall-back safety net. It does so within the budget reserve fund of $400 billion. So, I hope my colleagues will vote

against this amendment.

Senator Baucus. Mr. Chairman?

The Chairman. Senator Baucus?

Senator Baucus. Mr. Chairman, this is an amendment that I am very sympathetic to, but I really cannot, at this time support. It is similar to the earlier amendment addressing premiums.

We obviously want to enhance as much stability as possible so that seniors know they are getting good benefits. This bill, as you know, is an attempt to strike a balance. Essentially, in some respects, it is between the bill that Senator Graham has offered last year on drug benefits and the tripartisan.

Senator Graham's bill was more expensive. I think it was $500 or $600 billion. I have forgotten the amount. But that made the program much more stable, but there was less private plan efficiency.

On the other hand, the tripartisan proposal was one which has much less stability, but more private plan deficiency. What we are trying to do, is to strike more of a balance in between. That is why we are here today, frankly, on the threshold of marking up and reporting out a bill. That is, we try to find that balance between the two.

Now, I, frankly, would not be adverse if there were

more dollars so we could err a little bit more on the side of stability and still keep the same private plan efficiency. But we are where we are, and that is at $400 billion. This amendment would certainly break that, which would cause a budget point of order. But I am sympathetic with its intent.

I would hope that, perhaps between now and the floor, and even through conference, we could find some way to enhance seniors' assurance that this is really going to be an even better benefit than we know that it already is, without sacrificing the efficiencies that we hope to get by the legislation we are passing. I certainly appreciate what the Senator is trying to do.

Senator Rockefeller. Can I close, Mr. Chairman?

The Chairman. Senator Breaux would like to speak first, then I will call on you for closing.

Senator Breaux. I do not want to speak, myself. I would like to ask CBO a question, because we had looked at this in the tripartisan bill about having the government plan up front. The difficulty was, if that happened, then the private plans would not be able to come in.

When CBO looked at this, what was your analysis of what would be the effect on the private plans being available if it was up front instead as second, as a

back-up?

Mr. Lieberman. Senator Breaux, when we looked at this last year there was a proposal, I believe from Senator Graham and perhaps Leader Daschle, to try to have side-by-side non-risk bearing plans and plans that were at risk operate in the same markets.

Our conclusions were that that would be a very difficult environment for at-risk plans to operate in, and it would significantly increase the score. Based on that analysis, and obviously not having analyzed this bill, it is clearly in excess. It is in the tens of billions of dollars, I would think. I have no idea how much more than $10 billion, but it would be significant.

The Chairman. Senator Rockefeller?

Senator Rockefeller. I would just like to say, in terms of CBO, they got this amendment on Wednesday. They have not been able to answer any of our questions up to this point, except for one, which raised such a storm that it got an amendment passed. So, I am not necessarily moved, Mr. Lieberman, by hat you said.

With respect to the level playing field, that is exactly what I seek. I am not against having private plans compete. But, again--and tell me I am wrong if I am--I think it is anywhere between an 8 and 12 percent increase in cost because of the marketing and the profit

making and the rest of it, which neither I, nor my family, has ever had anything against, as far as I know, that is going to drive up costs. On the other hand, it is also allows them to get a better benefit because they get more money.

Now, on the other side you have people that are on Medicare and they are sort of stuck where they are. I think we have agreed that private plans will be able to offer better benefits.

So I am very interested in having a level playing field, too, and I would like to see people have a shot at that level playing field. I think my amendment would help.

The Chairman. Do you want a roll call vote?

Senator Rockefeller. I would.

The Chairman. Would the Clerk call the roll?

The Clerk. Mr. Hatch?

The Chairman. Mr. Hatch would vote no, by proxy.

The Clerk. Mr. Nickles?

Senator Nickles. No.

The Clerk. Mr. Lott?

The Chairman. No, by proxy.

The Clerk. Ms. Snowe?

Senator Snowe. No.

The Clerk. Mr. Kyl?

Senator Kyl. No.

The Clerk. Mr. Thomas?

Senator Thomas. No.

The Clerk. Mr. Santorum?

Senator Santorum. No.

The Clerk. Mr. Frist?

Senator Frist. No.

The Clerk. Mr. Smith?

The Chairman. No, by proxy.

The Clerk. Mr. Bunning?

Senator Bunning. No.

The Clerk. Mr. Baucus?

Senator Baucus. No.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. Aye.

The Clerk. Mr. Daschle?

Senator Daschle. Aye.

The Clerk. Mr. Breaux?

Senator Breaux. No.

The Clerk. Mr. Conrad?

Senator Conrad. Aye.

The Clerk. Mr. Graham?

Senator Baucus. Aye, by proxy.

The Clerk. Mr. Jeffords?

Senator Baucus. No, by proxy.

The Clerk. Mr. Bingaman?

Senator Bingaman. Aye.

The Clerk. Mr. Kerry?

Senator Baucus. Aye, by proxy.

The Clerk. Mrs. Lincoln?

Senator Lincoln. Aye.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. Mr. Chairman, the tally is 7 ayes, 14 nays.

The Chairman. Accordingly, the amendment is defeated.

Mrs. Snowe is next.

Senator Snowe. Thank you, Mr. Chairman.

I thought I would continue in this discussion and offer an amendment with respect to the geographic adjustor, along with Senator Lincoln.

Obviously, I am going to try a different approach to this issue. I think we have had a very constructive and extensive discussion on how we can have some assurances about leveling any fluctuations and variations with respect to the premiums.

I understand the difficulties inherent when you are trying to deliver a private plan. We learned that through the tripartisan approach. Obviously, when you

have a performance-based approach, as has been offered before in government-run systems, it is going to be far more costly. If you have a risk-based approach, obviously, with competition and choices, we have the ability to constrain the cost.

On the other hand, we do want to be in a position to level any of the fluctuations and stabilize the fluctuations in the premium. So, I feel that we ought to take a different approach in this effort and try to give the Secretary the discretionary authority to make decisions to include various factors, including utilization, in making this determination.

Already in the Chairman's mark there is a study that will evaluate national premiums and the payments that are made based on utilization and to account for those differences.

I think, in combination with this study and also the discretionary authority that we would grant to the Secretary in order to make some decisions and determinations, that we could level the playing field with respect to national premiums.

Obviously, we do not want to minimize the incentives that would be available in this legislation to offer high-quality care in plans and to offer them efficiently. On the other hand, we do not want to constrain the

Secretary's ability to make the necessary adjustments that might be essential in leveling these national premiums.

So, essentially, my amendment would give the Secretary the authority to make the discretionary decisions with respect to national premiums to include utilization, to include other factors.

Now, there are a number of issues that already, I think, will help to create more of a national premium. We obviously have a national definition of covered drugs. There are standards that are established by the administrative or therapeutic classes and categories.

There are risk management mechanisms. There is reinsurance that pays 80 percent of the higher costs that exceeds $3,700 in catastrophic caps, and also there are the risk adjustors that adjust payments to pay for health and demographics of the enrollees.

We also have the input prices with respect to the cost of drugs. So, I think that there are various issues here and criteria that will help to stabilize these premiums.

On the other hand, we do not really know for sure. There is a level of uncertainty with respect to how these premiums will be determined in the final analysis.

So, I do think it would be prudent to give the

Secretary the kind of authority that would be essential to intervening in some of these decisions in the event that it does not turn out the way we originally intended.

The Chairman. First of all, there is some concern that we all have about the issues as brought up. I have said that in regard to a previous amendment from the other side, obviously, I would say in regard to this. Our evidence, and our concern about it, is in my modification we called for a study of this to make a judgment later on of whether or not there was a problem here.

Now, this goes a little bit further than my modification, so I wonder if I could ask Mr. Scully to comment on the administration position, or your own feeling about it. But I guess I would like to know what the administration's position might be.

Mr. Scully. I hope this is the administration's position, but my own feeling about it is, as long as it is the discretion of the Secretary, then I think we could probably use that.

The concern that Senator Daschle and other people have raised is obviously a legitimate one. We do not want to come up with premiums and find out that they vary significantly between the regions. I think the issue is really to make sure we can look at the volume, intensity,

and utilization across geographic regions. I think this says "service areas," which I assume are the same thing.

But I think we expect that the premiums will not vary that much, but I think it will be helpful to the Secretary, if we find out there is a problem, to have the ability to make them more consistent based on this, I think it might very well be helpful.

So, I think especially since it is discretionary, and if it turns out that it could be problematic and we do not have to do it, I think we would probably be for it.

The Chairman. I wonder if I could, since I said I had some doubt, a lot of members have expressed some of this doubt, you have expressed a willingness to work with us, if between now and the floor, if the Senator from Maine would be satisfied if we would try to do this more thoroughly and see if we can work out something satisfactory to you between now and passage by the Senate.

Senator Snowe. Mr. Chairman, what is your specific concern with this amendment? That it goes further than you think?

The Chairman. I think it goes further than I think it needs to go, but obviously I have got some doubt in my own mind or I would not have pushed the study that is in my modification. That is about all I can say at this

point.

Senator Baucus. If I might, Mr. Chairman.

The Chairman. Go ahead, Senator Baucus.

Senator Baucus. This is a unique situation. Rural States are worried that they are going to come out on the short end here. Urban areas are worried they are going to come out on the short end here. We are just not sure. We do not know.

We do not have information. In addition to that, we want to make sure that the amendment itself is worded properly. I do not know that this one is worded improperly. I really have not had time to look at it.

My personal view is, we need something a little more than a study. I think, by the time we get to the floor, perhaps in the manager's amendment, we work with what Senator Snowe is suggesting, because I think it is a very good amendment. We are all trying to achieve the same goal.

By the time we get to the floor, my hope is we can find a way to deal with it with something more than a study, but it does give the Secretary and CMS a lot more authority to make these geographic adjustments. At least then they will have the authority if something goes haywire. Not that anything is going haywire here.

Senator Bingaman. Mr. Chairman?

The Chairman. Senator Bingaman?

Senator Bingaman. Thank you, Mr. Chairman.

Let me just raise some concerns I have about this. I have a chart here in front of me called "Projected Annual Medicaid Prescription Drug Expenditures by State." It shows that my State of New Mexico is by far the lowest in the prescription drug expenditures under Medicaid.

I am not sure that is exactly relevant to what the amendment deals with, but I am concerned that there are several factors that can lower utilization in a State. In my State, for example, the Indian Health Service provides services to a lot of people. I think that lowers utilization elsewhere in the health care system.

The VA. We have a lot of veterans in our State. I think that lowers utilization. We are a border State, and a lot of people, frankly, in the southern part of New Mexico go into Mexico to get their prescription drugs and that lowers utilization.

I am not sure that I would like to see the Secretary of Health and Human Services shifting more funds to another State that has a higher utilization with the misunderstanding that there is less need for adequate prescription drug coverage in my State.

So, I do not know exactly how this thing plays out, but I have real doubts about whether this amendment has

been adequately thought through and is ready for prime time.

Senator Nickles. Mr. Chairman?

Senator Lincoln. Mr. Chairman?

The Chairman. Senator Nickles, then Senator Lincoln.

Senator Nickles. Mr. Chairman, just reading the language of the amendment, I think it helps, frankly, Senator Bingaman and Senator Snowe, and it is not that much different from what you have in your mark.

To me, it does give the administration some authority and it does help close the differential. If I am reading it correctly, it says to adjust for geographic variations and to minimize variations in premiums for the standard drug benefit.

So, I would think it would help accomplish some of the things that Senator Bingaman and many of us feel. There have been significant variations. This is language basically giving the Secretary the authority to close some of those variations and be more uniform in eliminating some of the discrepancies. So, I would hope that we would adopt the amendment.

The Chairman. Senator Lincoln?

Senator Lincoln. Thank you, Mr. Chairman.

I just think that the whole issue here in terms of

Medicare is to try to provide a package for seniors that gives them the same security and stability that they have known in the current program. Medicare has certainly had a tradition of security and stability in premiums in both Part A and Part B. I think that is what we are trying to achieve. I thank the Senator from Maine for her hard work and focus on what we are trying to do here.

I think we have talked an awful lot about the concerns we have for our States, particularly rural States that do have high utilization. With all due respect to my colleague, our proximity to Mexico is closer than some, but not as close as others.

Not being able to access less expensive drugs like that, in many instances, is a factor, quite frankly. We take busloads down there at times just to access those better prices, but it is not something that is easily manageable.

I think Mr. Scully has mentioned to us that they are delighted to have the authority, but they are not necessarily going to act on it that quickly. So, at least it is a step in the right direction.

Hopefully, if the information proves to be true--I mean, we have got the facts from the Kaiser study that indicates the number of prescriptions per capita, that that translates in any way closely to those States that

have high elderly and Medicare recipients.

I think it is going to indicate that the utilization in some of our rural States, and in many of our States, is a huge factor that should be considered when we are talking about these premiums and making suer that they are balanced, fair, and equitable to everybody across the Nation.

So, I encourage us to move forward on it. If, between now and the floor, or at the floor, we figure out something that is more beneficial, we can certainly act upon it then. I am sure there will be another manager's amendment when we get to the floor. But I encourage my colleagues to recognize that there is certainly a concern there and we need to do something about it.

The Chairman. Senator Bunning, then Senator Daschle.

Senator Bunning. Thank you very much, Mr. Chairman.

I have heard numerous Senators on both sides of the aisle talk about stability in premiums. I suggest that this amendment, as it is written and I just read and re-read, does exactly what we want to accomplish.

If there is instability, it gives the Secretary a hand in authorizing a more stable premium and benefit. And I certainly support that, so I am going to support Senator Snowe's amendment and hope that others would do

the same.

The Chairman. I accept the amendment.

Senator Baucus. Let us voice it.

The Chairman. Those in favor, say aye.

[A chorus of ayes]

The Chairman. Those opposed, say no.

[A chorus of nays]

The Chairman. The ayes have it. The amendment is adopted.

Senator Daschle?

Senator Daschle. Mr. Chairman, I was just going to agree with Senator Bunning and others. I think I will stop while we are ahead.

The Chairman. Let me see. That was Senator Snowe.

Now, Senator Breaux.

Senator Breaux. Thank you, Mr. Chairman.

I have an amendment which is Amendment #3, which deals with the question of specialty hospitals and physician ownership. Currently under the Social Security Act, it prohibits physicians from doing what we call "self-referrals." It basically says that physicians cannot refer patients to certain designated health services where they have a financial interest in that facility.

There are two exceptions in the current law to that

prohibition rule. The first, is if it is a rural facility. The second exemption, is if it is for a hospital.

Now, to qualify under current law for the hospital exemption to allow a physician to refer patients to his own hospital in which we has a financial interest, the referring physician must be authorized, number one, to perform services at that hospital, which is not a problem, and that exemption also is referred to as the whole hospital exemption, which basically means that it has to be a hospital that provides full services, that provides emergency room care, that treats different types of illnesses, and does not specialize in a particular type of services.

We have asked for, and received, a GAO report that talked about the grave concerns that were being voiced about the growth of so-called specialty hospitals. The GAO report talks in terms of these specialty hospitals, which, in many cases tend to specialize in cardiac care, orthopedic care, surgical specialties.

These specialty hospitals are doing grave damage to your community general hospitals because they are, in essence, siphoning off or taking only those patients that have the highest reimbursements, leaving your community hospitals to have to run emergency rooms and take every

other type of patients for which reimbursement rates, many times, are very, very low.

What they have talked in terms of, is basically taking only the less sick patients, and that is having a tremendous adverse effect on the regular community hospitals.

In essence, what they are doing is cherry picking only those patients that are going to that hospital for only one type of service, and they generally have the highest reimbursements.

Now, it is interesting to note that these hospitals currently today only cover about 2 percent of the hospitals in the country, but they are increasing in numbers by a very rapid amount. The numbers of these hospitals have tripled since 1990.

I mean, quite frankly, a number of folks have figured out this is a way to provide health care by, I think, taking the cream of the patients and leaving the rest for everyone else. I think that is not what the intent of the law is.

So, Mr. Chairman, my amendment simply says that it clarifies the whole hospital exemption to exclude those circumstances in which a physician's ownership interest is in a hospital that primarily or exclusively is devoted to cardiac, orthopedic, surgical, or other specialties

designated by HHS regulations as inconsistent with the intent of the original law.

That is, to allow physician ownerships only where a comprehensive spectrum of inpatient and outpatient services are provided and where physician ownerships in specialty and self-referrals are insignificant in relation to the overall scope of services provided.

Now, the question has been raised by a number of my colleagues. I know Senator Daschle, and Senator Hatch, Senator Bingaman, and others have spoken to me about these hospitals that have already been constructed under what I would consider to be a loophole, and those that are in the process of being constructed and have already been approved.

I think it would be inappropriate to make this retroactive because these hospitals were constructed at a time when this was not specifically prohibited. Although I think the intent was to do that, it was not very clear.

So my amendment is intended to not apply to physician-owned specialty hospitals in existence on the date that the act goes into effect.

Now, what do we mean by in existence? Suppose a hospital is under construction. We need to work on that language to make sure it is not retroactive. But that is the intent of the amendment.

Could I ask, maybe, Mr. Scully, would you have a comment on this one way or another?

Mr. Scully. I have spent a lot of time on this over the years, Senator. I think we would support this amendment. The whole hospital exemption, I do not think, written by Mr. Stark originally on the House side, ever envisioned specialty hospitals. It was intended for 500-bed hospitals, not 20-bed hospitals.

I think if the administration had the legal authority, we would have already done this by regulation. We have determined we probably do not. We still might have tried, and were thinking about trying, to do this by regulation. We think it is the right approach.

I might add, also, this is symbolic of some of the problems we have when you fix prices for hospitals. We clearly over-pay for cardiac surgery and orthopedic surgery when we fix our prices. That is enough to have people start very successful specialty hospitals. Of course, that cross-subsidizes some of the lesser-paying things in community hospitals.

But specialty hospitals have a niche, and in some places we believe they are fine. The issue is, they have a financing incentive. Right now, if we pay a doctor $6,000 for a surgery and the hospital $10,000, the specialty hospital sells shares 50 percent to the doctors

and they share their profit with the doctors. So if they want to open a specialty hospital across the street because they are going to get better service, that is great.

But frequently--too frequently--they are doing it because they have a financial incentive. We believe the incentives are out of whack. Specialty hospitals still exist, and right now there is a giant magnet to create them, which is not appropriate.

Senator Breaux. I would just ask unanimous consent. I think the original amendment we sent out did not address the question of retroactivity.

The Chairman. It is accordingly modified.

Senator Breaux. All right.

The Chairman. I call the question. Those in favor, say aye.

[A chorus of ayes]

The Chairman. Those opposed, say no.

[A chorus of nays]

The Chairman. The ayes have it. The amendment is adopted.

Senator Thomas has an amendment. He is next.

Senator Thomas. Yes, sir. Thank you, Mr. Chairman.

The Chairman. Yes?

Senator Frist. Just so the Chairman will know, we

are going to probably have a vote on the floor at about 5:45 and then we will have another vote stacked with that. And that will likely be all of the votes on the floor tonight, but just in terms of our planning here.

The Chairman. All right. Thank you very much.

Senator Thomas. Mr. Chairman, this amendment prevents mental health counselors, marriage and family therapists to bill Medicare for services provided for seniors. And I have submitted this along with Senator Lincoln, who has disappeared.

It will result in increased choice for mental health providers for seniors and enhance the ability to have access. It is especially critical, of course, for rural seniors who are often forced to travel long distance to utilize the services of mental health providers that are recognized by Medicare.

Rural communities have trouble recruiting, of course, and so on. So in many small towns, mental health counselor, marriage or family therapist is the only healthcare provider in the area. Medicare laws that exist compounds it because only psychiatrists, clinical psychologists, clinical social workers and nurses can be paid. There is a disproportionately high rate of suicide among seniors, so I think it is an important one.

We have--and we have talked to you about this some, Mr. Chairman--an offset that has not yet been totally confirmed. This thing is supposed to cost, in five years, about $35 million. The offset, if it worked, would be about $500 million, so that sounds great.

But I have to tell you that it is not completed and if you would prefer to wait until we have more on that--Senator Lincoln is back I see. At any rate, that is where we are. We would like to have it accepted. And it is Amendment 19. Mr. Chairman?

The Chairman. I wonder if I promised the Senator from Wyoming that we would try to work this out when we know the exact cost and get an offset for it. Or maybe at that point, when we get more firm scoring from CBO--not on your amendment, but on the overall bill--we may be able to accommodate this on the floor.

Senator Thomas. Could we turn to Senator Lincoln?

The Chairman. I am sorry. Senator Lincoln?

Senator Lincoln. Thank you, Mr. Chairman. Those are extremely encouraging words. And I think that I just want to reiterate what my colleague from Wyoming has expressed, and just to express to my colleagues that mental health needs for older Americans are really not being met, particularly out in our rural areas. And the rate of suicide among older Americans is higher than for

any other age group.

Less than three percent of older Americans report seeing mental health professionals for treatment. And going to their primary care physicians is simply not enough. It is not providing them the kind of guidance and the kind of background that they need.

I think research shows that most primary care providers receive inadequate mental health training, particularly in geriatrics. So, I applaud my colleague from Wyoming for working with me and I appreciate his leadership in this area, and I am certainly pleased to hear from the Chairman that he is interested in working with us.

And again, I think the lack of access to mental health care providers is one of the primary reasons why older Americans do not get the mental health treatment that they need. And again, not surprisingly, this problem is exacerbated in rural and under-served areas and we really want to encourage the committee to focus on it. So, I thank the Chairman and I thank my colleague from Wyoming.

The Chairman. Would the Senator from Wyoming withdraw the amendment, then?

Senator Thomas. Yes, sir. If we work with you, maybe we can trade it for some Ethanol. [Laughter].

The Chairman. I would imagine that you have already satisfied me more than on Ethanol.

Senator Thomas. Thank you, Mr. Chairman.

The Chairman. We will work with you as soon as we get some more numbers on how to do it.

Senator Thomas. Thank you.

The Chairman. The Chair will now recognize Senator Conrad.

Senator Conrad. Mr. Chairman, I would like to call up my Amendment #7, Transitional Coverage for Certain Self-Injected Drugs.

As my colleagues know, under current law, Medicare Part B covers injectable drugs if they are administered by a physician in an office setting. However, if a similar drug is available that could be self-injected at home, it is not covered.

I do not think that policy makes much sense and it causes a significant burden for seniors with certain illnesses such as MS, rheumatoid arthritis, hepatitis C. The amendment I am offering would improve the lives of these beneficiaries by providing coverage of drugs that could be administered at home.

These drugs would only be covered if they replace drugs that are already covered if provided in a physician's office. The transitional benefit would

expire when a comprehensive Medicare drug benefit is implemented in 2006.

According to unofficial estimates by the Lewin Group, the policy could actually save money, $86 million in 2004 and 2005, because the home-administered drugs are in some cases less expensive than those administered in a physician's office.

In the interest of full disclosure, CBO has told me they did an analysis a year or two ago, and based on that analysis they would tell us there is a cost to the program. Their information is different than the Lewin Group, so I want to alert my colleagues to that.

This is an amendment that is similar to a bill that was endorsed by more than 40 patient organizations. To me, it is a common sense policy and I hope my colleagues would support it.

Now, I know because CBO had not done a score, that that may present a problem to the Chairman and the Ranking Member, and so I would welcome their suggestion as to how we proceed here.

I do think this is an important matter. And if the Chairman and Ranking Member believe this is something we could address before we get to the floor, I would certainly be pleased to welcome their ideas.

The Chairman. I think there are two things I would

like to say. One, that I think is a problem for 2004, but I am going to have to ask Mr. Lieberman to comment on that.

The other one is for Mr. Scully. It seems to me that the policy we have in this area just is not a common sense policy. I mean, we are willing to have the same therapy covered if there is a muscular injection, but if there is a subcutaneous injection, we do not pay for that. I do not understand that. It does not make sense. I mean, you are treating the same situation, right?

Mr. Scully. I have spent a lot of time on this, Senator.

The Chairman. Well, then tell me why it does meet the common sense test. If you have studied it, it must have some common sense.

Mr. Scully. I am not sure it makes common sense, but clearly has a financial breaking point, which is you have to be not usually self-injectable. We put out a new rule, and what with 27 Part B carriers, this had 27 sets of rules. We did simplify this last year by putting out clear guidelines of what was covered and what was not, which I think helped.

But probably the biggest example of this are the two leading rheumatoid arthritis drugs--which I am real familiar with because I have that--Remicaid and Embril,

both very good drugs. I think Remicaid can only be given in a doctor's office, and we pay for it. Embril can be given at home and so we do not pay for it.

And the basic breaking point is that we do not cover outpatient drugs. Where do you draw the line? If it is done in an institution, done in a doctor's office, done in a hospital, we pay for it. If it can be done at home, we do not pay for it.

And I think that is the whole issue, that we do not have an outpatient prescription drug benefit. And our view has been at some point, if you have to draw the line, if it can be done at home, we do not pay for it. If it has to be done in an institution, we do. And there are some drugs that break across that line, but having spent a lot of time on it, I do not know what Steve would say, but I assure you this would be a multi-$100 billion coster.

The Chairman. All right. Well, let me say, based on what you just said--Senator Breaux could say this better than I could--but when we get a comprehensive drug program, we will not have these bureaucratic decisions that do not make sense to me and we will cover all these, will we not?

Mr. Scully. Yes. But the issue would be, once again, you would be covering the existing ones under the

current bill, I believe. Under Part B, if it was done at a doctor's office, done in an outpatient center, done in a hospital, it would be paid for under the Part B benefit.

The Chairman. Well, I mean for the new program.

Mr. Scully. For the new program it would fall under the new drug program. If you are poor, you will probably get a better treatment than existing law. And if you are not poor, you probably get worse treatment.

The Chairman. Now, let us get to the crux of this thing. If this is going to cost money and we do not have money in 2004 to do that, what is the cost going to be?

Mr. Lieberman. Mr. Chairman, as Senator Conrad said, we have not completed an estimate of this proposal. Our estimate of similar proposals last year were that those proposals had significant costs associated with them.

And I believe, as I understand Senator Conrad's amendment, his intention is to have it have effect in 2004. So if the facts have not changed--again, I am sorry not to give you a straightforward answer, but we have not updated the analysis--but based on last year's analysis, this would clearly have a 2004 cost.

The Chairman. See, Senator Conrad we are up against the same thing where we had to adjust some of the

payments for our rural healthcare provisions of this bill. We just could not start all of it. And that is, directories all of our passing unemployment compensation and the childcare refundable bill last week, and I do not know what else. I proposed State aid as part of the last tax bill that we had.

Senator Conrad. Mr. Chairman, might I?

The Chairman. Go ahead.

Senator Conrad. Might I just say that the Lewin Group--which we all work with and we know is credible and serious--did an analysis and they show a savings of $33.6 million in 2004, a savings of $52.5 million in 2005. And I would ask this, that CBO has not had a chance to score this recently. Is that correct?

Mr. Lieberman. That is correct, Senator Conrad. We have not updated our score.

Senator Conrad. So maybe we could seek to get the new score from CBO, have a chance for them to review this, and have a chance for the Lewin people to get together with the CBO people.

Mr. Lieberman. We look forward to meeting with them again this year. We met with them last year.

Senator Conrad. Yes. As I understand, their assertion is there have been some change in policies that change the scoring outcomes. And maybe I could suggest

this to the Chairman and Ranking Member that we have a chance to see what that finding is. And then between here and the floor, sometime in this process if, in fact, this is affordable in the context of the bill, that we would have a chance to revisit it.

The Chairman. Well, of course you would have a chance to revisit it. And we would assume that you do not lose any rights just because you brought it up here in committee. And I think you understand that I have some sympathy for what you are trying to do.

Senator Baucus. I agree. I was thinking to myself, my God, why are we not doing this right away?

Senator Conrad. I would appreciate it. I would just say that I think this is especially important in a rural area. We just looked in our state. Seventy percent of the people are having to travel over 100 miles to get these injections on a physician's office that could be injected at home, and we could save them a lot of hassle. It would nice to be able to do it.

Senator Lincoln. Mr. Chairman, can I just add my support to what Senator Conrad is asking and hope that we can work through this?

The Chairman. Sure.

Senator Lincoln. I know the purpose of this is to provide prescription drugs and to really work at meeting

all these needs. I just think it is also to point out the innovation that is available here that I think would in the long run present a great deal of savings. So I applaud my colleague's efforts and want to encourage the committee to work with him.

The Chairman. Senator Santorum is the next one on our list to offer an amendment.

Senator Santorum. Thank you, Mr. Chairman. Mr. Chairman, I have 10 amendments listed, but I am only going to talk about a couple of them. And I will not ask for a vote on any of them, but I do want to bring them to the attention of the committee and to the Chairman's attention.

The Chairman. Maybe if you are going to withdraw them, then maybe there would not be an objection if you take up a couple together, if you could do it quickly.

Senator Santorum. I am going to do that, Mr. Chairman, as quickly as I possibly can. I do want to make a point, and that is I am very concerned about Medicare+Choice program being there by the time 2006 rolls around for this program to be implemented.

Senator Schumer and I have been working to try to get some higher reimbursements for Medicare+Choice. I understand there is no money in 2004, and so I understand that this amendment is not a viable amendment at this

time.

But I would just suggest to the Chairman that if we want to have any these programs around by the time that 2006 rolls around, we need to do something in the relatively short term to keep these programs viable.

And I was just talking to the Leader about that, and there may be even some things we can do fundamentally to those programs to help in the short run so they can be in position to offer benefits in 2006. So that is number one. I would just ask for the Chairman's thoughts and considerations on that as we go to the floor.

The other issue is one that Senator Conrad and I mentioned, and that is I have an amendment on stabilizing Medicare payments for dialysis treatments. Senator Conrad is going to sponsor that.

And again, I would ask the Chairman for his consideration in dealing with that issue between now and the floor. It is an important issue. It is the only prospective payment payee that does not get a market basket adjustment because it was the first one to go to that system and it really has had a tremendously deleterious impact on the accessibility of dialysis to obviously a critically important component of our healthcare delivery system, and that is those who are on dialysis. So, those are the two.

The third one, and I will talk just again briefly about is an amendment, which is Amendment #4.

Senator Conrad. Would the Senator yield for just a moment?

Senator Santorum. I would be happy to.

Senator Conrad. Mr. Chairman, might I just comment on this?

The Chairman. Yes.

Senator Conrad. And I just make a pitch for that same provision, the stabilized reimbursement for providers of end-stage renal disease: 365,000 Americans require dialysis services.

The MedPAC, the Medicare Payment Advisory Commission, has made recommendation that suggests dialysis providers are not appropriately reimbursed. They have found that rural dialysis providers typically lose 15 percent on every service they provide. Clearly, that is not a sustainable situation.

And as the Senator from Pennsylvania indicated, this is the only one in this category, the only one, that is not provided a market basket update. So I would hope very much that we could correct that unfairness in the system.

Senator Santorum. I thank the Senator. And I just want to say, since 1983, they have had two increases

totally 3.6 percent in 20 years.

Senator Bunning. Senator Santorum, would you yield?

Senator Santorum. So this is an area that the value in current dollars of what we were reimbursing them is 70 percent lower than what it was. So, this is a problem. It is a problem we can fix. And I am hopeful that Chairman will be cooperative.

Senator Bunning. Senator Santorum, would you yield?

Senator Santorum. I would be happy to.

Senator Bunning. Thank you. On your Medicare+Choice, this is a provision that is losing favor right now because of the reimbursement rates. And it gives seniors another option to traditional fee-for-service Medicare.

In Kentucky and many other States, we only have Medicare+Choice in very few areas, one in Louisville and one in Northern Kentucky, and we are about to lose the option of having this included in 2006 if we do not do something about it before this.

I think we should not give up on these plans as an alternative to seniors and believe they should be fairly compensated. I think your amendment, Senator Santorum, would provide a financial boost to the Medicare+Choice

program so that companies currently serving Medicare beneficiaries will continue to stay in the market, and it might even entice other Medicare+Choice people to get into the market. I hope we can work on this in the future. And I hope that we can have some of these ready for 2006.

Senator Santorum. I want to thank you, Senator Bunning. Thank you for your support. And again, I ask for your consideration on both of those.

The final amendment is Amendment #4, which is Medicare Reimbursements for Critical Access Health Centers. This is an amendment to try to meet the need of under-served populations.

HERTSA estimates that 53 million Americans do not have access to primary care services. And as you know, we have critical access health centers that get a special reimbursement. But there are a group of health centers in low income areas that do not get that favorable reimbursement and treatment, and those are religiously affiliated ones.

And there is a provision in the statute that says that--and this is the only reason they do not meet the criteria-- 51 percent of the health center's governing board have to be patients of the clinics.

Now, there are exceptions for Indian tribes,

government agencies and other things like that, but there are no exceptions for religious organizations who happen to have clinics in these under-served areas.

I understand, and I would like to ask the administration, my understanding is the administration has a favorable position on this idea. Mr. Scully?

Mr. Scully. I am not sure we have a full position, but I am very aware of this. The real issue, to get the religious, is I think, essentially many areas of the country. Catholic hospitals primarily have community clinics.

And it is largely Catholic community clinics that cannot be CACs because of the board provision. I am not sure we looked at the scoring, in fact, but I think it is probably a pretty good idea. If you look at where the CACs are located, they are heavily in the northeast. And as you go further west and south, there are fewer and fewer.

And there are a lot of places where their Catholic hospitals that have community health clinics that get paid differentially solely because they are affiliated with a hospital than a separate board. So I think it is a good idea generally, but I am not sure we analyzed it totally.

Senator Santorum. Mr. Chairman, I do not have a

score for this, obviously. But I would just ask, Mr. Chairman, I think this is a good idea.

Go ahead. Do you have any other comments?

Mr. Scully. I was going to say, generally, the CACs are paid for for grants at HERTSA. So it would have an impact on appropriated funds, but it would also have a Medicaid impact, a little bit of Medicare, but more Medicaid if there is a score to it.

Senator Santorum. My provision deals just with Medicare. It does not deal with Medicaid so as to be relevant to this legislation. So, I would just ask the Chairman that I wanted to bring it up. I will withdraw the amendment, but I am hopeful that we can deal with this as we get to the floor.

The Chairman. Before we go vote, I just wonder, even though only half of the committee is here, if we could have some indication out of the members both that have not had their first turn as well as everybody else how many amendments we might have. Maybe we should do this through the staff. Would each of you who are here tell your staffs how many amendments?

Senator Baucus. That way we will have more.

The Chairman. Yes. All right. Let us do it this way. How many are you going to offer?

Senator Lincoln. Well, I have got four.

The Chairman. Twenty-four to start with, but how many are you going to offer?

Senator Lincoln. I have got four and I will probably withdraw three of them.

The Chairman. All right. Senator Bingaman?

Senator Bingaman. Well, I have four, three of which I might wind up offering, one of which I am sure to offer.

The Chairman. All right. So, Senator Conrad?

Senator Conrad. I had seven. Initially, you were gracious enough to take two of them, and two of them we have under discussion. So, I would just have one more to offer.

The Chairman. All right. Senator Breaux?

Senator Breaux. One.

The Chairman. Senator Daschle?

Senator Daschle. None.

The Chairman. Senator Rockefeller, do you know how many amendments you might offer yet?

Senator Rockefeller. Two.

The Chairman. Two.

Senator Snowe?

Senator Snowe. No. I do not have any more. And I want to thank you for those that you did accept, Mr. Chairman.

The Chairman. All right. Thank you. Senator?

Senator Thomas. One for discussion.

The Chairman. Senator Kyl?

Senator Kyl. None.

The Chairman. All right. And Senator Frist, one.

Senator Bunning?

Senator Bunning. None.

The Chairman. All right. That will give us a rough idea. Thank you. We will be back after the second vote immediately. So I hope people go over and vote and then vote very quickly on the second vote and immediately get back.

[Whereupon the meeting was recessed at 5:56 p.m.]

EVENING SESSION

[6:35 p.m.]

The Chairman. Just as soon as the staff gets to the table, we are going to proceed. We have got seven members, and under the rules, with seven members we can discuss amendments and vote on amendments.

Senator Bingaman, would you be willing to start with your amendment?

Senator Bingaman. I am glad to, Mr. Chairman.

Mr. Chairman, I would start with Amendment #8 and explain that one, and then see what the Chair's preference would be. I would like to see if we could get agreement on this.

This relates to DSH payments, Disproportionate Share Hospital payments. There are several provisions that you have included in the mark, which I strongly support, intended to try to help safety net hospitals. And particularly in our rural communities, these are the hospitals that provide a great deal of health services to uninsured individuals.

Private plans are paid off of the fee-for-service rate. So those payments get rolled into the private plan payments. These DSH payments, which are add-on payments, get rolled in to the private plan payments.

The concern I have is that if this new law that we are trying to enact here does result in quite a few Medicare beneficiaries enrolling in private plans, then the safety net hospitals would receive substantially less in their DSH payments.

This would not be one of our intended consequences. I think there is no intent here to harm safety net hospitals in order to provide a prescription drug benefit to Medicare beneficiaries.

As the Medicare Payment Advisory Commission, which has been referred to several times by people here in the last few hours, they advised Congress on this subject in the past and they said plans are overpaid to the extent that they do not pass on DSH payments to the appropriate hospitals.

I think Congress recognized this problem when dealing with graduate medical education or GME payments to health plans provided that there would be a direct payment to teaching hospitals in that case.

In the case of Medicaid, when we authorize much greater use of managed care in Medicaid back in 1997, we carved out DSH payments to health plans to ensure that that money got to the hospitals intended to receive it.

We are now moving Medicare more into this managed care model. And I believe that it is very important that

we try to have the same kind of carve out for Medicare for safety net hospitals.

I think this is the time to protect and carve out these payments and ensure that safety net hospitals are not adversely affected if a substantial number of people leave traditional Medicare and go into the private plans.

So that is the nature of the amendment. It is designated Bingaman Amendment #8. And I would hope we could get strong support for this. I think it is very consistent.

Maybe I would ask Ms. Fishman. I know she is familiar with the way that we treated GME payments and tried to carve those out and also the Medicaid payments, if I am correct in my assertion, that we made special provision in the law so that those payments got to the hospitals they were intended to go to, if she would have any comment on that.

Ms. Fishman. I believe it was in VBA 1997 that the Congress carved out the direct graduate medical education payment and paid it to hospitals where teaching occurred when a managed care plan used those hospitals.

Now, indirect medical education adjustment was also carved out. This was done over a period of years and is paid to teaching hospitals directly. This is a similar kind of construction that would carve out the

disproportionate share payments.

Senator Bingaman. Mr. Chairman, I would point out the major benefit of this is that it does not add any cost to the bill. This is essentially trying to ensure that the DSH payments that we intend to get to the safety net hospitals actually get there. And since they are an add on, they do not go to the private plans, but instead go to the safety net hospitals that were intended to receive them.

The Chairman. First of all, the fact that there is not any cost is obviously very beneficial. We do see some problems, though, with how it might impact the plans that we are trying to establish. But I have some sympathy for what you are trying to do because you know we are trying to help these hospitals generally.

And I was wondering if there was any way we could get you to withdraw it as long as we would continue to work on it and see if some of these concerns we have could be dealt with.

Senator Bingaman. I think I would be glad to do that, Mr. Chairman, and work with you in good faith in the next several days to see if we could get this in a form that was acceptable to the Chairman and could make some sense.

If I might, if that is the course the Chairman would

like me to follow, could I mention a related amendment, which I would also handle the same way, if possible and not through prior vote?

The Chairman. Yes. I think that would be appropriate. And then I would go to Senator Frist after you.

Senator Bingaman. All right. This relates to the community health centers. And again, it is an amendment to try to avoid unintended consequences. These community health centers are largely paid their costs in Medicare. And the rationale is that Medicare should not underpay community health centers and thereby force those health centers to support the Medicare program.

And what I am trying to do is to ensure that we try to do a similar thing here in Medicaid. When we moved people into managed care, this was recognized. Senator Hatch and Senator Conrad at that time, offered an amendment to provide a wrap-around payment to community health centers.

And that became part of the law so that community health centers would not be adversely affected by the fact that people were moving into these managed care systems. And my hope would be that we could have that same kind of wrap-around payment written into this Medicare revision.

I have a letter from the National Association of Community Health Centers that I have distributed to all members. It should be in everyone's pile of materials that you have there. And again, this is one of these issues on which I do not intend to force to a vote at this point.

But I would very much appreciate a chance to work with the Chairman and see if we could solve this problem as well, since we solved it in the case of Medicaid. Let us see if we can solve it in the case of Medicare.

The Chairman. Before I answer your question, I wonder if we could just defer your amendment for a minute because I have got to have my staff look at it.

Senator Bingaman. Sure.

The Chairman. You are not asking much of me, but I want to make sure, if I tell you we can work with you, we can work with you.

Senator Bingaman. That is fine.

The Chairman. So we will just defer your amendment for a minute and go to Senator Frist.

I want to say to people who have not offered amendments yet that I want to do an accommodation, at least within the next half hour, for Senator Rockefeller, who has got an engagement tonight because his wife is getting an award and I would like to make sure he can be

there with his wife and he has to leave in a little while.

Senator Frist, go ahead.

Senator Frist. Thank you, Mr. Chairman. I will be brief. I have eight amendments. And I will briefly run through three of these really in about three or four minutes and then we can move onto the next amendment on the other side. Several of these, I will be withdrawing shortly.

My first amendment was an amendment that has been addressed by the Chairman and the manager, and it has to do with hospice contracting with another hospice.

This amendment lets Medicare-certified hospices to contract with other Medicare-certified hospices to obtain certain core services when necessary and to allow hospices to contract with highly specialized nursing skills that may only be needed occasionally. This provision addresses staffing shortages. The Chairman and the Ranking Member have dealt with this in the manager's package.

My second amendment is one that deals directly also with hospices. In this amendment, I seek to allow those Medicare beneficiaries who regularly see nurse practitioners, or clinical nurse specialists, or physicians as their primary care giver to continue to be

cared for by that health professional if they elect to go in a hospice.

This correction allows greater access and continuity of care for our seniors. I feel most people would agree that Medicare seniors should not have to change their primary care givers just because they elect a hospice.

It is my understanding that it is mainly a technical correction and that is has been, or will be, dealt with in the manager's package.

The Chairman. Well, I think we will just accept it at this point.

Senator Frist. I would appreciate that.

One last one that I will mention on this round has to do with an issue that is critically important that we have not talked about today at all, and sometimes it does get overlooked if you are a senior, and that is the role of our community pharmacies in Medicare modernization and in our underlying proposal. This is my Amendment #5.

It allows, under the Medicare Advantage plans that offer mail-order benefits, beneficiaries would have the option to fill their long-term prescriptions in community pharmacies.

And I mention this because a lot of people express concern with the fact that you get a 90-day prescription or even a longer prescription, you receive that mail

order in the mail without having direct contact, maybe not even having that option to have direct contact with the pharmacist.

Anyone who is on prescription drugs knows the value of being able to ask those questions directly with a pharmacist. This particular amendment would allow beneficiaries to have that option to fill these long-term prescriptions in community pharmacies.

It provides beneficiary flexibility and it recognizes the importance of these pharmacies and the pharmacists in taking care of our seniors. Many seniors are on many, many medicines and I think it is very important that we address it.

The Chairman. Senator Frist, my staff and Senator Baucus's staff have been discussing this. What we would like to do, is we think we can accommodate you, but we cannot do it right now and would like to work with you over the next few days on this issue.

Senator Frist. Mr. Chairman, that would be fine. Again, the underlying premise and the point that I want to make is the critical role these local pharmacists play and the service they provide on the front line.

I our effort to streamline and electronically deliver medicines and deliver medicines through the mail, I do not want that important link to be lost. And if we

can address that underlying bill over the next several days, that would be satisfactory.

The Chairman. Before I let you ask a question, I would like to comment on the last point. If there is any segment of the healthcare delivery that is nervous about anything that Congress is doing on prescription drugs, I can tell you after two years or more, it is pharmacists.

And I think that I would associate myself with any movement to impress upon them that there is nothing we are trying to do to hurt them. At least it is not our intent in any way.

And I do not see any ways in which we change anything that exists today that would do that. But I would like to associate myself with your remarks, and particularly your last statement.

Senator Conrad. Mr. Chairman?

The Chairman. Yes.

Senator Conrad. Might I ask the Senator if I might be a co-sponsor of his amendment with respect to the pharmacies? Just in going through my own father-in-law's illness, we found that it was the pharmacy that was the one place where the prescriptions were being coordinated.

Even though there were multiple physicians, multiple specialists, all of them prescribing things, the only place it came together was at his pharmacy. And I really

think that would be a tremendous loss if that was not included.

Senator Bunning. Mr. Chairman?

The Chairman. Senator Bunning?

Senator Bunning. I just want to ask Mr. Scully, who is----

The Chairman. Is this about the Frist amendment?

Senator Bunning. This is about the Frist amendment.

The Chairman. Go ahead and ask.

Senator Bunning. I am 100 percent for the Frist amendment. I would also like to be a co-sponsor, if you will allow me.

Senator Frist. Without objection.

Senator Bunning. But Mr. Scully, how does this change the bidding with the HMOs and the PPOs as far as prescription drugs are concerned on the long-term basis?

See, under my program that I had with the Federal Healthcare Benefit Plan, I cannot go to my local pharmacy, I have got to go to a drug house to get a 90-day supply. I can get a 90-day prescription from my doctor, but my plan will not allow me to go to my local pharmacy because they will not fill it.

Now, how will this affect the bidding for the overall 10 regions that we are going to have?

Mr. Scully. I sure wish I was not answering this one.

Senator Bunning. Well, I want you to answer.

Mr. Scully. Well, obviously, I hate to disagree with Senator Frist. I think the concept here--and we have been through a lot with the community pharmacists on our drug card the last couple of years, they have very legitimate concerns about volume moving to mail order, and we fully understand that. I think that is probably what this is trying to address.

And I think there is a concern to make sure the PBMs are balanced and do not push mail order. Our estimates are, I do not think there are going to be that many people going to mail order, but it is clearly the case that mail order can be cheaper.

And if you tell PBMs or people bidding on these contracts that they can do mail order, they have to substitute for the community pharmacy at the same cost, I think it is fairly clear we will probably raise the price of the bids and dilute the benefit a little bit.

Senator Bunning. You missed my point. My point is that, will the PPOs and the HMOs allow us, under the bidding process, to go to our local pharmacy?

Mr. Scully. Well, at least through the structure, and I am not totally familiar with it exactly, but almost

all--certainly the President's proposal--required every bidder to have a community pharmacy network, and within a certain amount of miles you had to the community pharmacy, but it also allowed mail order.

And I believe that Senator Frist's amendment effectively says that as an alternative to getting mail order, if you get a 90-day prescription or 180, you have to require that you can go get the same thing filled at a community pharmacy, which may cost more.

Senator Frist. Mr. Chairman, I would add that if we said no mail order, everything goes through community pharmacies, you do have the problem that you cannot capture all of the efficiency.

What I want to prevent, and it could be paid for and you should be able to have variable co-pays in order to establish a hierarchy in terms of how you pay for it. What I want to make sure is that the electronic mail order of prescription drugs will not specifically exclude you from being able to go to that community pharmacy.

Senator Bunning. Me, too. Thank you.

Senator Frist. And that is not in the underlying bill. That is specific exclusion.

Mr. Scully. Senator, I think certainly what the administration believes, if all it has said basically is that every bidder had to provide a community pharmacy for

the benefit, we could totally be supportive of it.

Senator Frist. Because the issue is a complex one, it is one that we need to address. And since it has not been talked about, I wanted to put forth this amendment. It probably does involve some cost, and therefore I think it is appropriate not to vote on the amendment right now because I do not have a way to pay for it.

But it is something that I think we do need to address in the underlying bill. I withdraw my amendment with the understanding, over the next two or three days, that we can do just that.

The Chairman. All right. Thank you very much.

I would like to respond to Senator Bingaman. This may not be very satisfactory, but a major issue was have is what is the score. And what I would like to pledge to do for you, Senator Bingaman, is to work very hard to get a score and get one soon, and then make a determination with you at that point.

Senator Bingaman. This is on the community health issue?

The Chairman. Yes.

Senator Bingaman. Right.

The Chairman. I think it is central to whether or not I could support your amendment.

Senator Bingaman. All right. Well, I will

certainly be glad to wait until the Chairman has all the information he needs and then we can revisit it.

The Chairman. All right. Thank you very much.

Now, Senator Lincoln, you did not want to defer to Senator Rockefeller for a few minutes?

Senator Lincoln. Sure. I would be glad to.

The Chairman. All right. Senator Rockefeller.

Senator Rockefeller. Thank you very much. My marriage is at stake.

Mr. Chairman, I want to present two and one, certainly for a vote. This has to do with protecting employer coverage, and we have discussed that. And I think the point was made by CBO for instance, in Rockefeller #2.

The CBO said that 37 percent of participants with employer-sponsored insurance will have their employer coverage dropped. This is 11 percent of all Part B enrollees or over four million people.

I hope to help with this problem. Chairman's mark currently contains a catastrophic limit on spending by beneficiaries. However, out-of-pocket costs counting toward that limit only include costs paid by the beneficiary.

Any costs for which the individual is reimbursed by their former employer could not, under the present

situation, be counted towards the out-of-pocket costs. This definition of out-of-pocket costs, which is called the true out-of-pocket, is not an honest reflection of the individual true drug spending.

It has two effects. It extends the amount of time that it takes for the beneficiary to reach the catastrophic limit and secondly, as I indicated, approximately a third plus will lose their coverage.

So what the goal of the legislation would be would be to encourage employers who were currently providing drug coverage to their retirees to continue to do so, not to force them out by making their contribution on the beneficiary's behalf meaningless. That is what is best for our seniors. In other words, let count the employer's contribution.

This amendment removes the true out-of-pocket concept and replaces it with a real out-of-pocket concept, which better reflects the seniors' true drug spending and will keep employers from dropping out of the drug coverage business, I hope.

The Chairman. I would like to have a CBO tell us, and I know you cannot give us a very definitive fiscal picture on this, but some sort of a ballpark figure on what Senator Rockefeller's amendment would cost and who would those dollars go to.

Mr. Lieberman. Thank you, Mr. Chairman.

Senator Rockefeller's characterization is accurate. There are two moving pieces here. One is, if you keep the out-of-pocket threshold the same as it is in the bill so that at the level of spending--and I am sorry this is going to get slightly complicated--the $3,700 true out-of-pocket, Senator, I assume that is what you would want to keep at the level of total drug spending that it is now for everybody.

In other words, everybody would get the same level of out-of-pocket spending as if they were uninsured, as if they had no other third party payment. So that means that $5,813 of drug spending for an uninsured person, that is when the catastrophic provision kicks in currently. I assume your amendment would be to keep that level for people, for example, who have third party payment like employers.

Senator Rockefeller. Yes. So that the employer's contribution would count for their out-of-pocket costs.

Mr. Lieberman. So that if that were the case, that would add--I do not have a precise estimate, but it is clearly in excess of $10 billion and less than $100 billion.

Senator Rockefeller. Thank you.

Mr. Lieberman. And I think that the other thing

that one could do, and I am not suggesting this, but if one took the level of total drug spending higher for everybody, you could, ignore the so-called true out-of-pockets categorization and count everybody's out-of-pocket spending whether or not they actually spend it out of their pocket.

Senator Rockefeller. What would happen if you forgot the $3,700 part, which you emphasized and simply said they are paying X amount of money and that gets counted as part of what the cost of paying for that drug is, which is not now allowed?

Mr. Lieberman. Right. If that were the only change so that money that employers are not structuring out of the benefit, --

Senator Rockefeller. That is what I am talking about.

Mr. Lieberman. -- that would increase the cost by in excess of $10 billion over the eight years of the benefit. And several multiples of that would be my guess.

I was just pointing out that if you wanted to move to your concept and stay within the budget window, the $400 billion, the other way to do that is to move the catastrophic threshold up for everybody. That would be a very significant raising of the threshold.

Senator Rockefeller. Yes. I am not sure that I want to get into that. I have an offset.

The Chairman. All right. Mr. Scully.

Mr. Scully. Mr. Chairman. I would just add, probably will not make my friend, Senator Rockefeller, happy, but we have scored this. And I do not know the exact score, but I think it is a little over $30 billion. Maybe it is as high as 40. And I guess our concern, as we discussed earlier this morning, is trying to find a balance policy wise to not buy out existing retiree benefits.

And under the Senate bill, you do, in fact, give them about a $500 to $600 buy out for existing employee benefits already because you are not getting the catastrophic benefit, but you are getting the lower level benefits.

And I think our concern is that this is probably $30 to $40 billion that effectively buys out existing coverage instead of covering new people. And employers are going to get a substantial portion of their existing spending bought out. And I guess the sensitivity is trying to buy them out enough to keep them in, but not so much that you are just replacing existing dollars.

Senator Rockefeller. Mr. Chairman. I have no way of fighting back. I have an offset language, but I have

no way of fighting back because I have no way of knowing what it would cost except what I hear today because that has not been delivered to us. I think it is a very important principal. And the 37 percent is a very shocking figure. And I would like to have a vote on my amendment.

Senator Baucus. Mr. Chairman.

The Chairman. Senator Baucus and then we will vote.

Senator Baucus. Mr. Chairman, I would agree that 37 percent is shocking. I focused on that. And I think when other Senators focused on that figure early today is a bit alarming. And I am very sympathetic. I am trying to figure out a way how we address that. I understand there is a balance here. You do not want to give too much.

This is something that I know Senator Kennedy is very interested in, how to reduce that percentage in a way that does not control too much money to employers. But I do hope--and I am going to have to vote against this amendment, but I do hope that between now and the floor we are going to find a way to help reduce that 37 percent because I think it is a bit high.

The Chairman. Would the Clerk please call the roll?

The Clerk. Mr. Hatch?
Senator Hatch. No.
The Clerk. Mr. Nickles?
Senator Nickles. No.
The Clerk. Mr. Lott?
The Chairman. Nay, by proxy.
The Clerk. Ms. Snowe?
Senator Snowe. No.
The Clerk. Mr. Kyl?
The Chairman. No, by proxy.
The Clerk. Mr. Thomas?
Senator Thomas. No.
The Clerk. Mr. Santorum?
The Chairman. No, by proxy.
The Clerk. Mr. Frist?
Senator Frist. No.
The Clerk. Mr. Smith?
Mr. Smith. No.
The Clerk. Mr. Bunning?
Senator Bunning. No.
The Clerk. Mr. Baucus?
Senator Baucus. No.
The Clerk. Mr. Rockefeller?
Senator Rockefeller. Aye.
The Clerk. Mr. Daschle?

Senator Daschle. Aye.

The Clerk. Mr. Breaux?

Senator Breaux. No.

The Clerk. Mr. Conrad?

Senator Conrad. No.

The Clerk. Mr. Graham?

Senator Baucus. Aye, by proxy.

The Clerk. Mr. Jeffords?

Senator Baucus. No, by proxy.

The Clerk. Mr. Bingaman?

Senator Bingaman. Aye, with Senator Rockefeller.

The Clerk. Mr. Kerry?

Senator Baucus. Aye, by proxy.

The Clerk. Mrs. Lincoln?

Senator Lincoln. Aye.

The Clerk. Mr. Chairman?

The Chairman. No.

Senator Kyl. Might I be recorded as no?

The Chairman. He would be recorded as no, in person as opposed to proxy. Senator Kyl.

The Clerk. Mr. Kyl votes no.

Mr. Chairman, the tally is six ayes, 15 nays.

The Chairman. Accordingly, the Rockefeller Amendment is defeated.

Mr. Smith. Mr. Chairman?

The Chairman. Senator Smith, you would be next. But he had two amendments and he will be done. And I will call on you.

Mr. Smith. I know this means something to his family, so let us let him finish.

The Chairman. Senator Rockefeller.

Senator Rockefeller. It is big time.

I am just asking that the Ranking Member and the Chairman work with me between now and the floor consideration. It is interesting that in the Chairman's mark, for the first time in the history of the program, it would prohibit some Medicare beneficiaries from receiving a Medicare benefit.

And I will not go into this anymore at this point. But this was in the tripartisan proposal last year. It includes two changes on Medicare beneficiaries that will be eligible to participate in the new Part D Medicare drug benefit including those who are eligible for Medicaid.

As with any other benefit, Medicare would be the primary payer for prescription drugs, Medicaid would be the secondary payer for those Medicare beneficiaries who are also eligible for Medicaid.

Whether that is understood or not, I simply wanted to put it forward. And I will not ask for a vote. I

would ask if the Chairman and the Ranking Member would find if there is some way that we can work on this.

The Chairman. Before I speak to that, could I ask Mr. Hayes to comment on it, please?

Mr. Hayes. Sure. Mr. Chairman, last year in the tripartisan bill, we had a provision that had the benefit delivered through Medicare. And that resulted for low income beneficiaries for the dual eligibles that you are speaking to.

And that resulted in a complex arrangement with the States, between the States and the Federal government by which the Federal spending net that displaced the state spending that is currently spent through the Medicaid program resulted in a dramatic increase in Federal expenditures.

And in order to not have a huge score for doing that, we had to do what was called a claw back in the bill that had the States continuing to share the costs for the Medicare expenditures.

As a result, we have this situation where we deliver benefits to these beneficiaries, we then clawed the money back from the States through a decrease in the Federal match rate through the Medicaid program through a formula that had to have a proxy for how much these States would have spent even though they are no longer incurring these

expenses.

And then, as a result, the administrative complexity and cost was unfortunately very high. So that is why in the Chairman's mark, we have avoided that complexity and tried to nevertheless guarantee the Medicare and Medicaid protections to the low income beneficiaries.

Senator Hatch. Could I ask a question? How much is this going to cost per year if we would adopt this?

Mr. Hayes. In our work with CBO over the weekend looking at this, our understanding, through various things that we looked at to try and accommodate variations on this approach, appeared as though it was going to add as much as $20 to $25 billion over.

Senator Hatch. I heard it was $40 billion a year. That would include the Medicaid beneficiaries as well.

Mr. Hayes. I think the issue is that it costs as much as $60 or $70 billion over 10 years for the low income benefit. And then what you do through this claw back is you extract money back from the States by reducing the Federal match rate.

Senator Hatch. So to Federalize it is about $40 billion a year for over 10 years.

Mr. Hayes. I do not know that I will take your word for it. I do not have that number in front of me,

Senator Hatch. That is what I understood.

Senator Rockefeller. Mr. Hayes, could I ask if the claw back aspect was included in this? Is it possible that there would be a net no cost States are held responsible?

Mr. Hayes. The problem that we ran into is how to appropriately claw it back in a way that would not result in an unfunded mandate on the States so that we did not result in imposing new costs on States that the Federal government was not paying for. Some States were winners and some States were losers under this approach. It became as administratively complex as what I am trying to describe was. It was even more complex to try and figure out how to do that on a state-by-state basis.

Senator Rockefeller. Mr. Chairman, I am aware of the complexity and the controversy involved in this. I hold out my hope that I can work with the Chairman and the Ranking Member, but I am also extremely sensitive to other member's feelings about time and I have one very quick and very important additional amendment.

The Chairman. You have a third one?

Senator Rockefeller. Yes. This is not an amendment I want to vote on, what I am talking to you about. I am just asking can we consider that between now and the floor, if there is any way?

The Chairman. We will take a look at it.

Senator Rockefeller. Thank you very much.

The third one has to something--and I am not in a position to say at this point whether Senator Snowe is supportive or not and so I am not going to, but it used to be the Snowe/Rockefeller Access to Cancer Therapy Acts, which would make Tom Scully levitate seven feet off his chair, which is really worth watching. It is really worth watching.

Now, in 1993, Congress created a unique Medicare drug benefit for all handicaps or drugs. I have been working on this forever, all right, so I am vested. But only if the drug is equivalent to drugs provided "incident" to a physician visit, i.e., if it is injected. This is not Ken Conrad's. This has to do with cancer drugs. At that time, there were about nine. Now there are about 43 that can be used.

At present, about 90 percent of cancer drug therapy is covered by Medicare, either in a physician office or in a reimbursable oral form. But by 2010, as much as 25 percent of cancer drug therapy will be in the form of oral drugs that are not currently covered.

The Access to Cancer Therapies Act will build on the current Medicare policy by ensuring coverage of all anti-cancer drugs whether oral or injectable, that they are available to Medicare beneficiaries. I am almost

finished.

The Act will provide beneficiaries with access to all these new therapies. Again, there is, I think, 43 cancer therapies which are now available. We have had endless press conferences and all kinds of things on this with people who would be affected.

They are much less toxic. They are much more convenient. They are more clinically effective. They are more cost effective than many currently covered treatment options.

In the last Congress 57 Senators cosponsored this particular bill. Due to budget constraints, I would like to modify my amendment to allow all cancer drugs, oral and injectable, to be covered under Medicare Part B until the drug benefit is implemented, only until that point.

It is terrible that our patients are denied access to new technologies due to this inconsistency. It is also terrible in my judgment that in some cases, Medicare is forced to pay for more expensive drugs due to this inconsistency.

The intention of this amendment is to give the secretary flexibility to cover oral alternatives to expensive injected drugs already covered. And as for the offset question which is coming, I would like to ask Mr. Scully, there is a provision in the mark that I do not

understand; it is Section 414. If you have had a chance to get that, could you explain this provision and give me an estimate of its cost?

Mr. Scully. Explain the oral cancer provision or the 414?

Senator Rockefeller. No. It is Interim Payments and Study for OPD Drugs and Biologics. Page five of 13.

Mr. Scully. Section 414.

Senator Rockefeller. You got it.

Mr. Scully. Yes. I just have the summary. If I could just read it for one second. No. This provision for small rural hospitals under 100 beds essentially holds them harmless from outpatient PPS.

Senator Rockefeller. Top of the page.

Mr. Scully. Four fourteen?

Senator Rockefeller. Yes. Four fourteen, page five out of 13. Interim payments and study for covered OPD drugs and biologics.

Mr. Scully. Oh, interim payments. Yes. Well, Senator Nickles is not here. This was in the Chairman's addition to the mark. And you picked on a particular addition to the Chairman's mark the administration has vast problems with. We really do not like this policy. This policy, essentially, unbundles all the outpatient drugs and biologics.

Senator Rockefeller. What I asked for was an estimate of its cost.

Mr. Scully. I believe--and I have not scored this, but my guess would be this is at least $2 billion a year. Now, it depends on how it is done. And it is not quite described.

But we spent $21 billion a year on outpatient payments. A good piece of that is drugs. This basically would take drugs out of the existing provisions and pay them at the current 95 percent of AVP, based on May of this year. So even if we reform AVP, we would still keep paying at the old, completely bogus rates.

Senator Rockefeller. All right. Mr. Chairman, I have an alternative. In that I am only asking this be done over the next couple of years. I have another offset which I can explain that will cost about $2 billion. And I would like to have a vote on this.

And I recognize I am invading everybody's time and I am very, very grateful. I am inclined to strike the section which you like, Mr. Scully, but I am willing to go with what the Chairman suggests.

Now, my offset is to make drug pricing data available to the States under Medicaid drug manufacturers now pay rebates to States which are based in part on utilization data reported by the States and pricing data

reported by manufacturers to the centers for Medicare and Medicaid services, that is you.

Under the rebate statute, this pricing data is confidential and may only be used by CMS to calculate the rebates payable to States by manufacturers. This provision would allow CMS to provide States the pricing data in order to allow them to set reimbursement rates that are more in line with actual process.

This offset simply makes information available, which as we all know is a hallmark of true competition. It does not create a new bureaucracy or set of prices I have written down here. I think it should be noncontroversial. [Laughter].

The Chairman. Would the pay for that he describes, will that cover that?

Mr. Scully. It is hard to know.

Senator Rockefeller. Mr. Scully, I have never heard you say that before. [Laughter].

Mr. Scully. Thank you. One thing I can assure you is it is not noncontroversial. The pay for he is talking about is to make A&P public for Medicaid rebates, which probably would lower Medicare prices for drugs, arguably substantially, but it also infers impacts that the States may not like because it may also cause complications of the Medicaid drug rebate, so that is a think through.

We do, in fact, collect average manufacturers price and it is not public. And my Medicaid side of Medicaid cannot share with the Medicare side. And it has been a fairly strange provision for years.

On the other hand, were the A&Ps made public, I would have to think through the implications of that. But it would probably save quite a bit of money. And certainly, Senator Nickles--it is not fair because he is not here, Section 414 would clearly cost money, the addition of the Chairman's mark.

Senator Hatch. But does it not provide drug price information to the States that is already proprietary information? Is that what it is?

Mr. Scully. No. We collect it and by statute, when we told the manufacturers are required to give us their average manufacturer price, by statute.

Senator Rockefeller. Mr. Chairman, I would like to suggest that this is a complicated discussion and it is a very important one. And it is a very, very important one that I have been working on for 12 years, I think. Is it not, Tom?

Mr. Scully. That is it.

Senator Rockefeller. And there are 43 drugs out there, nine are paid for. That was because that was back in 1993 that we finally got that passed. All of these

new drugs have come on. They are much better. People want them. They can take them orally.

I would not ask for a vote in this tonight, but that sensible heads can sit down and see if there is a way. Because I am talking about short term, only until this thing kicks in.

Is there a sensible way to make this work using the offset that I have suggested, or perhaps some other offset. The subject matter is really important and really worth it. I recognize that the approach is not easily explainable with time pressure.

The Chairman. I think as long as he does not want to bring it to a vote, I will go to Senator Smith now for his amendment.

Senator Rockefeller. Can we discuss it because it is still open?

The Chairman. Well, yes. It is open. I did not realize.

Senator Rockefeller. I mean, for us to discuss.

The Chairman. Well, then, as long as you want to discuss it, I want --

Senator Rockefeller. No. I do not mean now. I mean between now and the floor, which is not very long.

The Chairman. Absolutely.

Senator Rockefeller. All right.

Senator Snowe. Would the Senator yield?

Senator Rockefeller. Yes.

Senator Snowe. I certainly am supportive of the Senator's amendment because obviously these coverage options are absolutely critical for seniors and particularly those with disabilities.

And I would like to work with you to see if there is some way that we could offset the cost associated with it. But I think it makes a great deal of sense to provide this type of transition until the prescription drug benefit kicks in. Mr. Chairman.

The Chairman. Well, I would suggest if you are going to look at a pay for, this one here it seems to me is going to affect reimbursement to pharmacists, right? They are going to pay. It is going to come out of their hide, to some extent, the offset that he described?

Mr. Scully. The manufacturer price, for Medicaid it could, yes, part of it could.

The Chairman. Sure. Senator Smith?

Mr. Smith. Thank you, Mr. Chairman.

I am offering an amendment that would help frail seniors all around the country. I was pleased to see in your mark that it establishes a new Medicare+Choice option specialized Medicare+Choice plans for special needs beneficiaries.

Your legislation defines special needs beneficiaries as those who are institutionalized, newly eligible or those determined by the secretary to be so. My amendment seeks to broaden the number and type of health plans that can offer this new type of choice for beneficiaries to include health plans that serve a disproportionate share of institutionalized dual eligible nursing homes, certifiable or other chronically ill beneficiaries.

This would broaden the group of programs which would be allowed to operate without a Federal demonstration, including social HMOs or SHMOs, as they are known. The Wisconsin Partnership Plan, the Minnesota Senior Health Options program in addition to Evercare, which was covered by your legislation.

Mr. Chairman, these specialized Medicare+Choice plans serve a growing segment of the most expensive Medicare beneficiaries, those with multiple chronic care needs, beneficiaries of five or more chronic conditions representing 20 percent of Medicare population, but they account for 66 percent of the cost.

Compared to seniors with only one chronic condition, those with five or more conditions visit their physicians four times more often and receive five times the numbers of prescriptions. They cost Medicare $13,700 per year compared to $980 per year for those with but one

condition.

Specialized disease management programs can reduce hospitalization rates for nursing homes by 50 percent. And other disease management programs have cut the risk of nursing home admissions by half, representing a significant savings to both Medicare and Medicaid.

The Chairman. Senator Smith, I know that you have had a long term commitment to this. And I appreciate that commitment very much. And as everyone here knows, we are having extremely thin resources for the year 2004, but probably only for that year.

Every priority on the table, including my own rural provisions have been scaled back to some extent. We hope to find ways around that. And at this time, and under these budget constraints, I would say to you that you have got my firm commitment to work together with you on making these specialized plans a viable option for the frail elderly, and to do that obviously into the future. So you have my commitment to making these plans a more steady feature of our Medicare program.

Mr. Smith. Thank you, Mr. Chairman. Your commitment is as good as gold with me. And so on the basis of that, I withdraw my amendment and I look forward to working with you to this common end.

The Chairman. All right.

Senator Conrad. Mr. Chairman?

The Chairman. Senator Conrad.

Senator Conrad. Might I just associate myself with the remarks of Senator Smith. I think he has offered a very constructive amendment and one that really is very important because it goes again at that element of the Medicare population that is using a tremendous amount of the resources.

And this is the place where we could substantially save money and improve health outcomes by this kind of focus. And so I would like to associate myself with the Senator.

Mr. Smith. Senator Conrad is exactly right, Mr. Chairman. This is both compassionate and cost effective. It is good for the patient. It is good for Medicare.

The Chairman. Senator Lincoln, you are ready now with one of your 24 amendments?

Senator Lincoln. Yes, Mr. Chairman. I have scaled them back remarkably. Do I just do one at a time? Or would you like me to talk about them and withdraw?

The Chairman. Well, if you are going to do all of them and withdraw, do them all at once.

Senator Lincoln. All right.

Well, first of all, Mr. Chairman, I would like to associate myself with the comments from the Senator from

West Virginia. I think Senator Rockefeller is right on track with what we want to do in innovation here, particularly in the oral anti-cancer drug.

With no injectable version, they are not currently covered. If there is anything that makes sense, it is to make sure that we make these types of innovative new opportunities available to our Medicare population. And I hope that Mr. Scully and others will work with the gentleman and the rest of us to make sure that happens.

Mr. Chairman, the first of the amendments that I would like to talk about is in regard to the fall back provision, the underlying mark provides a drug benefit in the traditional Medicare through the private drug only insurance plans and if that private insurance plan does not emerge in an area of the country, the government will provide a drug benefit to the seniors in that area through the Medicare program through this fall back mechanism that we have been talking about.

But the fall back plan is available to beneficiaries for only one year at a time. We have discussed this earlier today. We have talked about the fact that private plans are going to be give a two-year contract opportunity, so I do not see any reason why it is that we are limiting these entities to only one year at a time.

If the private insurers decide to just test whether

they want to offer a benefit in a community, the beneficiaries lose the access to the fall back plan even if the new plan is significantly more expensive or restrictive or if they are just testing and they do not really intend to remain. They do not have the intentions there.

And many of us have experienced this in our rural States where we have seen these private plans come in. They have not spent much time. They are in and out like a flash. And many of them have not in the past provided the full benefit.

So our concern, I think, is really warranted in examples of what we have seen in the past. I do firmly believe that the fall back plan should be more stable for our seniors if they are put in a position where they have to take that option.

They have no other option to take, why should we not want to make it as stable as we possibly can if, in fact, it is what we have named it and that is a fall back. They are getting nothing else. They have the opportunity for nothing else. Why would we not want to create it in a more stable way.

I guess, push come to shove, what if they really like the fall back plan better than the plans that are offered by the private insurers? I have to just consider

many of the examples I have in my constituency of an older woman with a chronic illness using multiple prescription drugs. She lives in rural Arkansas and she enrolls in a drug only insurance plan, but then the plan leaves, the fall back comes in, somebody else decides to come in and give it a whirl for whatever reason, hopefully with the intention to stay, but not always the case. And the fall back leaves the very next year.

Her formulary may change, her premium may change, her preferred network pharmacist may change. I just think it is really inexcusable that we would ask our seniors, when we put then in a situation to have to deal with a fall back plan, that all of a sudden we provide them with this enormous confusion of a year-to-year decision, particularly in our more difficult areas or areas that are more difficult to serve.

So I would just ask Mr. Chairman, that one way to minimize that confusion is to give these fall back plans the same opportunity that we are giving the private plans that come in.

And we would just like to ask that hopefully, over the course of the next however long we are going to spend between now and the floor that we could work through that issue and really look at the fairness and the equity in what we can present to particularly people in rural areas

that are those more likely going to be finding themselves with no other choice but a fall back plan.

And again, those in our rural areas tend to be lower income. They are more difficult to serve, usually more costly to serve. And the confusion is just going to mount for them.

So, Mr. Chairman, I just encourage the committee and I hope that you and your staff and Senator Baucus and his staff will be willing to work with us to look for something that is going to make more sense and certainly reflect the fairness that we want to see for all constituencies across the country.

The Chairman. I think I have been very clear on this with other members who have spoken similarly on this that obviously I have shown some concern about this. I will continue to show that concern. I hope I also will have the ability maybe to show you that maybe you do not have concerns.

But at least we have a backup plan, which shows our good faith in making sure that we serve all parts of the country and do it adequately. The other side of the coin is, though, we do not want a government that does not have to worry anything about resources to kill the dynamics that we think is going to come from a private plan. And that is the other side of the coin.

But I think we have a very good balance. It is my job to show you that we have that. And it is also my responsibility to look at concerns you have and something we might do to tailor this a little bit different to satisfy you. But I am not totally in agreement with you, but I am not certain enough of what we have that I feel that I can ignore what you are saying.

Senator Conrad. Mr. Chairman?

The Chairman. Yes.

Senator Conrad. Mr. Chairman, I have the same amendment and I am wondering if I could just speak on the same subject for a moment and then not offer the amendment?

The Chairman. Yes. Proceed.

Senator Conrad. I thank the Chairman. I thank my colleague. We have both filed virtually the same amendment. And I have done so for really the same reasons.

Under the current proposal, seniors would not be offered certainty from year to year because they could be required to leave a fall back plan, go into a private plan, the private plans fail or withdraw for whatever reason, they are back in the fall back plan, then two more private plans come in. They could be back in the private plans.

You could have a circumstance in four years with senior citizens in four different plans with four different formularies with four different rules with respect to premiums, with respect to other elements of the plan.

I think that has the potential to create confusion and chaos. Since we first learned the details of this proposal, the Chairman and the Ranking Member have moved to address this concern by requiring the private plans to commit to serving two years rather than one in a region. I think that was a very positive move. I commend the Chairman and Ranking member for that.

It seems to me that will provide better stability to seniors and drug only plans, but what about the seniors in the fall back plans. The last we were told, CBO projected 30 percent of seniors would be in the fall back plans. Why not provide the same kind of stability in those plans as being provided in the private plans?

So I would urge my colleagues, we have now got scoring on this. It is $1 billion dollars. We know there is additional money available before we go to the floor that is available to address some of these concerns because of scoring issues that are brought to our attention today.

I would just hope very much that the Chairman and

the Ranking Member would strongly consider the proposal the Senator from Arkansas and I have in our filed amendments.

The Chairman. I might ask our staff. Because we have worked so hard on this, I would like to get for the record right now, some expertise from my staff. Mr. Hayes?

Mr. Hayes. Yes. Mr. Chairman, the Chairman's mark contemplates a system to provide stability to the private plans that would enter the market. In the tripartisan bill in previous efforts, there was more risk that the private plan had to take on to participate.

In the proposal this year, the Chairman's mark contemplates a phase in of that risk so that in the first two years, there is much less risk required of the plan so that they can participate.

There are also two additional features to add stability to the plans that participate. The administrator has broad discretion to reduce the amount of risk in a region to ensure that two plans can participate and continue to participate over the long term.

And in addition, there is a plan stabilization fund which plans will contribute to and be able to use the resources from that to lower premiums and remain in

markets in future years.

We have put all of these provisions in and the Chairman has put all of these provisions in the Chairman's mark in order to be able to ensure that that stability will be there in the private plans.

Senator Bingaman. If I could just conclude on this point by saying, I think all those are worthy. I think the question is, whether we do the same thing for the fall back plans in terms of additional stability with respect to a two-year assurance.

I really think the one significant weakness we have left in this bill, given the fact that we are limited in our money is this issue. And I really think it merits our strong consideration before we reach conclusion.

The Chairman. Senator Baucus?

Senator Baucus. Mr. Chairman, I heartily agree with the Senator, particularly for the two for private. I do not know why we do not do two for the fall back. And the remaining big issue still is instability and uncertainty.

There are other issues, too, like the gap coverage and so forth. But I very much hope we can find a way to work this out and that is to find a two year fall back resolution. I do not know if we can or not, but I am going to work hard to see if we can.

The Chairman. I would suggest that the administration give some thought to this. It is maybe something we are going to have to deal with. I am not saying I want to deal with it, but it may be something we have to deal with and we ought to know what we are doing and we ought to know what other people are proposing to do. There is a certain philosophical obstacle here. And I think we ought to think it through carefully.

Mr. Lieberman. Mr. Chairman, if I could?

The Chairman. Yes. Mr. Lieberman.

Mr. Lieberman. I just want a quick word. I know Senator Conrad conveyed that we had estimated that this could be less than a billion. The only thing I want to convey-- and this is something that you alluded to in terms of your staff and Senator Baucus's staff's work-- this is an incredibly complicated area where the precise wording of the legislative language would matter enormously as whether it is less than a billion or could potentially be quite significant in cost.

There are ways to do this where it would be clearly less than a billion, but I just want to say this is one where details do matter.

Senator Daschle. Mr. Chairman?

The Chairman. Senator Daschle.

Senator Daschle. On this point, we talked about

this quite a bit today. And I have two concerns about this issue. One is whether or not it is one year or two. But I am still very troubled by this period from September when a determination is made that two plans are not going to be available, to January when a decision has been made, not only which plan is going to be provided for a backup, but all the provisions of that plan, first of all, and then the notification of that plan, and then the implementation of that plan all in a period of a couple of months.

I must say, if I were 25 years old and I were subjected to all of that, I would be concerned. But if an 85- or a 90-year-old person is put in that position, I think we really have some concerns that have to be addressed.

And I think as we look to this whole issue of backup, we still have some homework to do. And I hope that on the floor we can all work together to try to accommodate some of these issues prior to the time we vote on final passage.

Senator Snowe. Mr. Chairman?

The Chairman. Yes.

Senator Snowe. I think this is a valid issue of concern. And I would be interested in hearing from Mr. Scully as to how you visualize this being implemented in

response to what Senator Daschle just raised. Because I do think it is a very valid issue that obviously we ought to be concerned about.

I, too, would be concerned about the issue of turning it around, the paperwork, the burden, the impact on seniors. So how plausible is it that we could really do it in that short time frame?

Mr. Scully. I think it is plausible. I think the concerns obviously have some merit to them. But I think our actuaries have pointed out--and CBO has a different opinion--we have actuaries. Do you have any actuaries?

Mr. Lieberman. Yes, I do, actually. I have two.

Mr. Scully. Fifty-two. The bar actuary, believe it or not, did not assume that any region would go without bidding. And the reason is that the administrator, whoever that may be at the time, has the discretion to keep using risk quarters to narrow the risk until someone shows up.

And our actuaries believe that in each of the 10 regions, the universal appeal will probably bid on this is pretty small. There is probably 15 PBMs and pharmacy chains, Walgreens, others that are likely to bid on this. And the universal appeal likely to bid is reasonably small. We have dealt with a lot of them in developing our drug card proposal.

We believe that the real issue is how much risk do we have to assume in the Federal government before somebody shows up. Believe me, someone will show up in each one of them.

So the real issue is, if it turns out during the bidding process that a plan does not show up, we are fairly certain some will show up, but once you get the risk bands narrow enough.

But eventually, essentially, we are just going to be picking up all of the costs and do what we do in the Medicare program, which is paying them a management fee and bearing no risk.

So I do not think that the process--I understand the concern about the turnaround, but having gone through this every year with Medicare+Choice is much more complicated. We actually do it county by county all across the country. And here we are going to be doing 10 regions.

It is complicated. And we go through this every year. And every county in the country now from M+C plans, but I do think we can do it in the course of three or four months every year.

Senator Snowe. Mr. Chairman, could I just follow up on the question?

The Chairman. Yes.

Senator Snowe. I think the goal is to ensure that it is going to be a seamless service and totally uninterrupted. I think that is the goal. And that is the issue that has been raised by seniors.

I know in my conversations and meetings with a number of seniors over the last two years, even working on the tripartisan plan and how to guarantee that you have a strong fall back that is seamless and totally uninterrupted when it comes to providing that coverage. And that is the question here.

Mr. Scully. I think, Senator, this may sound not connected, but if you look at what is going on with the States right now where they are starting to put together multi-state PBMs, a number of people out there in this universe that can provide these benefits either through States and Medicaid or through this and Medicare is pretty limited.

And the switching, I am almost concerned there are not going to be enough people. So I think it is very unlikely you are going to have huge switches. The universe of people likely to be out here contracting is probably about a dozen people at the very most and really six or seven.

I am actually, in some ways more concerned there will not be enough different entities out there bidding.

I do not think the changes are going to be as violent as some people think.

Mr. Hayes. Mr. Chairman. If I could also clarify the amount of the authority that Mr. Scully is referring to would allow the administrator to dial down the risk, if you will, to virtually the same amount of risk as is in the fall back plan already.

So you can almost think of this as having two fall back plans available in the region under this sort of dialed down of the risk authority that is already in the Chairman's mark.

The Chairman. Senator Santorum, then I would suggest that we go on to Senator Lincoln's following amendment. Senator Santorum.

Senator Santorum. Yes, Mr. Chairman, thank you.

I oppose the amendment. The reason I do is, I think Mr. Hayes' commented on it and Mr. Scully did, too. The fact of the matter is, these backup plans, I think, are going to be more problems than they are going to be help. And the reason is is that if you have a backup plans that all the folks who are bidding on this project know is available, there is a very high likelihood that you are not going to get a sufficient amount of bids. Because why, if I am a PBM, am I going to take risk if there is a backup plan there that I have no risk.

So I think that making backup plans more attractive is actually a real bad idea. What you want to do is you want to eliminate the backup plan and make people bid where the administrator has the ability to adjust the risk as to what is the acceptable level of risk that can get you the competitive bids to get a good balanced system where people will stay for the long time because they are at the appropriate level of risk.

I think backup plans just assure you that you are going to have a no risk program where the government is going to pick up the entire cost and it is going to be a lot more costly program to the Federal government. It is going to be a lot less efficient program. They are higher cost, is that not right, these programs. So it is going to be a higher cost system. You are not going to get any more benefit to the individual. And you will probably have just as much turnover or maybe even more, as if you went with a program that had an appropriate setting of risk in a real competitive environment.

So my feeling is, anything that helps the backup plan, count me against. I think it is a bad idea. I think the proper thing is, if the risk needs to be dialed down to zero--is there anything in the bill that prohibits if the backup plan was not there--for the risk to be dialed to zero or half of one percent?

Mr. Scully. That is the backup plan.

Mr. Hayes. The Chairman's mark allows the administrator to dial the risk down to everything except exactly zero.

Senator Santorum. All right. So you can dial it down to one-tenth of one percent, which is basically zero, without a backup plan. I just think that having the backup plan there is a big problem. I think it is a big red flag that says let us go to zero and let us work from there. And I think in the end it is going to cost more and deliver less.

Senator Daschle. Mr. Chairman, could I just respond to that real quickly? Mr. Chairman?

The Chairman. Senator Daschle.

Senator Daschle. Just real quickly. As I understand the bill, you do not even know what the backup plan is until it is clear that you do not have the two plans to begin with.

So you would not see the backup plan in competition with the two plans because the bidding for that plan and the design of that plan would not take place until after it was clear in September that the plans were not available in the region.

So I do not see it as a competitive thing. What I am concerned about, I think a lot of people have lamented

the slow deliberative style of our bureaucracies, and Tom does a great job in a lot of respects, but it is asking a lot it seems to me, to say from the end of September to he January 1 that you are going to have to bid it out, you are going to make sure that everybody has all the information they need, you are going to make sure that it is all administered and implemented by January 1, regardless of what you think of the backup plan.

I think that is a very, very tight envelope within which to make all of this happen. And that is my concern. It is not how good or bad the backup plan is.

Senator Conrad. Mr. Chairman?

The Chairman. Mr. Scully wanted to talk.

Mr. Scully. Yes. Mr. Leader, the September date, which is parallel to the filing date of the Medicare+Choice plan, which was only last year with our support, by the way, moved back to September first because it is easier for the health plan. They have to calculate their bids in May or June for an M+C plan for the next year.

In this particular case, I think September is a technical thing. It might be too late. And we are going to have a copy of the process. And one thing that might help is to move that first bidding process back to where the Medicare+ used to be, about June, to give us more

time. I think your point is valid. But I think if we had another month or two to go through this process, it might simplify things.

Senator Conrad. Mr. Chairman?

The Chairman. Yes.

Senator Conrad. Mr. Chairman, just in response to the Senator from Pennsylvania, for those of use from very rural areas where we have seen no interest from Medicare+Choice plans coming into our States, we have 10 or 15 people now, in my entire state signed up in Medicare+Choice plans. That is not 10 or 15,000, that is 10 or 15 people.

Senator Daschle. That is 20 percent of the population. [Laughter].

Senator Conrad. We have very low degree of confidence that these plans or anything like them are going to be attracted to our areas for the purpose of providing these benefits.

That means, we believe we are already told by CBO, 30 percent of people are going to be in these backup plans. I bet you a disproportionate number of those people are going to be in rural areas.

And I go back to the question of what is the senior going to experience out there? They start in a backup plan because no private plans come into the area. And

yet if subsequently private plans come in, they have got to go out of the backup plan, they go into a private plan.

Then maybe the private plan fails just like we have seen with Medicare+Choice plans all across the country, failure after failure after failure. Then they go back into the backup plan.

Then, some other private plans come forward and they are forced again out of the backup plan. Every time, their premium could change. Every time, the coinsurance could change. Every time, the formulary could change.

Now, this is not an academic question. And it is a reason why I believe we have got to find additional ways to make this more stable so that the people who are on the receiving end are not getting whipsawed back and forth, back and forth in a lot of confusion. I tell you, if we want to have people upset, let us be shoving them from one plan to another year after year.

The Chairman. I would hope that Senator Conrad would give us a chance to show him he might be wrong between now and the time this bill passes the Senate.

Senator Conrad. Or that he might be right and there is a way to accommodate it.

The Chairman. Well, there might be. I am open.

Senator Santorum. Thank you, Mr. Chairman. Just a

fundamental difference between what we are talking about here and the Medicare+Choice plans is that the Medicare+Choice plan is by county and this is by region, which is a multi state region. Yes.

Probably, there are very few counties in North Dakota where a Medicare+Choice plan would want to participate because you do not have any kind of concentration of population and so it makes no sense. But when you are in a region with five, six, seven other States

Senator Conrad. Our problem is it is North Dakota and South Dakota and Wyoming and Montana and Nebraska.

Senator Santorum. Maybe we could readjust those regional lines. I do not know. But the point is, that is still a much larger concentration than some of the counties that you represent and therefore is a much more viable economic unit.

The Chairman. I do not know what you guys got in your milk chocolate, but I thought after that last vote this was going to wind down. [Laughter].

And besides, on 1:00 o'clock on Monday, we are going to start this all over again anyway. Senator Lincoln, on your next amendment.

Senator Lincoln. Thank you, Mr. Chairman.

So we hope we can work on that one. We will not go

back into it.

The next amendment I had offered was the chronic care management. Understanding that certainly finances are an issue for us in this bill and we cannot seem to get scoring and we are not real sure how much it is going to cost or where it is going to come from.

We have gotten somewhat of an estimate of about $2 billion. I know there is a pilot project in there, but there has also been an awful lot of discussion in the committee about the innovation of the management of chronic care and the fact that we need to do more of it.

And I am hoping that as we move forward in this bill, we can look for some of those areas where we can find resources and we better know what these are going to cost.

All I am seeking to do is to improve the Medicare system in a narrow and targeted fashion by establishing a limited flexible care coordination fee-for-service. I think very strongly that the benefit would improve health outcomes and help to control the high cost of care for people with multiple chronic conditions.

We need care management because these people have multiple chronic conditions that result in high use of Medicare services, the high use of prescription medications, high Medicare costs and certainly the

inability to manage one's own care due to cognitive impairment, such as Alzheimer's Disease, is an additional indicator of a need-for-care management.

A chronic illness like Alzheimer's Disease has an even bigger impact on what we are doing. There was a report released today by the Alzheimer's Association that illustrates the need for my amendment. It shows that 10 percent of Medicare beneficiaries have Alzheimer's, and almost all, 95 percent of all of these beneficiaries had at least one other chronic condition.

These beneficiaries are costing Medicare three times as much as others. When you look at the cost of 13,207 versus $4,453 per year, Mr. Chairman, I appreciate what we have done so far in the pilot project, but I do have to say that looking for the innovation in the way that we can modernize Medicare providing higher quality care for less money is absolutely essential, I think, and the ultimate goal of what we are trying to do here.

The coordination of care can improve health status and reduce hospitalization. It can certainly help frail elderly beneficiaries and their families navigate a complicated and fragmented system and receive improved and coordinated services.

Some would argue that this kind of effective care management can only happen in capitated management care

plans. I just think that it would be a complete disservice to beneficiaries to assume that enrollment in managed care plans is the only answer to the challenge of chronic illness.

For the foreseeable future, the majority of beneficiaries will remain in somewhat of a fee-for-service plan and that system must respond to their conditions.

So, Mr. Chairman, as we look at the disproportion amount of Medicare expenditures that are spend on beneficiaries with chronic conditions. Beneficiaries with five or more chronic conditions comprise 20 percent of the Medicare population, but 60 percent of the program spending.

Now, I know CBO will not score those savings. They do not look too far ahead, just exactly what we have got right here. But I just plead with my colleagues that as we look at the growth in the population of the elderly in this country, we are going to go from 40 million Americans to well over 70 million Americans over the age of 65.

We are so under prepared as a nation, not only in what we have currently to provide the aging population, but with an increase in numbers like that, if we do not start preparing for a coordinated care effort--and it is

not going to happen over night. We have got to start now.

So I just plead with you, Mr. Chairman to remind that there is five of our Senate Finance Committee colleagues that are cosponsors. And I urge all of my colleagues to join me in working with the Chairman to see if there is not some way we can come up with the $2 billion that it costs to really provide this chronic care management piece in there in more than just a pilot project. And so instead of offering that amendment, Mr. Chairman, I would really like to plead with you to work with us as we move forward to the floor.

The Chairman. We will try to work with you on that. Yes.

Senator Lincoln. All right. Thank you, Mr. Chairman. I appreciate that.

I would just like to mention two others, if I may. There is a sense of the Senate on the therapy caps, and I know you have been very interested in working with that. The caps on seniors that we right now is unbelievable. We have got seniors across this country that are saving their physical, occupational and speech language therapy because they know that there is a cap.

They are scared to death. They are not going to use their therapy in the first six months of the year because

they are scared they are going to fall and break their hip and they are going to need that therapy later on. And because they know it is capped, it is, unfortunately, I think, a disservice.

I know CMS has reported that while the majority of enrollees will not exceed an annual 1,500 limitation on rehabilitation services, approximately 13 percent of the seniors and individuals with disabilities covered by Medicare will be forced to pay for medically necessary services out of their pocket.

So I just encourage you to work with us. I know specifically the problem with the 2004 funding, and that is a critical issue for this. And if there is any way possible that you and your staff can work with us on that, it would be much appreciated.

And I think the last, Mr. Chairman, is the insulin syringes that I mentioned earlier today. And I do not know what has come about since then. I know that CBO has given it actually a much higher scoring than some of the earlier estimates.

Medicare Part B does not currently cover insulin or syringes used to inject insulin for the majority of the enrollees. I do think it is a ridiculous oversight, especially when, of the seven million or so Americans over 65 with diabetes, 40 percent inject insulin every

day to control their diabetes.

And simply providing syringes for insulin syringes will go a long way to helping seniors keep their diabetes in control. And we know that the ultimate cost, the higher cost of the complications from diabetes and our seniors is astronomical. So it is a small piece. It is something that I think could be certainly cost effective. And I hope the committee will work with us between now and the floor to look at that.

The Chairman. Well, we will have to get a score on that last point. On the physical therapy, I will ask Mr. Scully, for a long period of time, you delayed enforcement of that cap. You could just continue to delay the enforcement of that cap, can you not? And then we will not have to worry about the scoring.

Mr. Scully. Yes. I wish I could, Senator. And I delayed it last year. I had to make a call last November about the therapy caps actually being implemented. It appeared at the time in November, that Congress was going to pass something to delay it and so I had the discretion to delay it six months because I had to make a call in November about whether to implement them in January.

We did not calculate anybody that got occupational or rehab therapy the first six months of this year. We did not count it, so effectively, the $1,500 cap did not

start until July 1 this year.

But I talked to my lawyers quite a bit and the law says there is a therapy cap. And I did not think I had the discretion to assume the law would change once. Doing it twice, the law is very clear, there is a cap in the law.

And as of July 1, we were counted. So effectively, they only started calculating it as of July 1 this year. There are some small number of seniors that may actually hit those caps, but effectively, it is a six month $1,500 cap. We, I do not believe, have the ability to suspend it any further. The law is very clear. I wish I could.

The Chairman. Senator Bingaman, you have a comment.

Senator Bingaman. I had another amendment I wanted to bring to your attention at some point.

The Chairman. You can do that just as soon as Senator Kyl gets done.

Mr. Lieberman. Mr. Chairman? Mr. Chairman, I am sorry. Just very briefly.

The Chairman. Yes.

Mr. Lieberman. On Senator Lincoln's last amendment, it is so rare that we have a score, it seems today, that I wanted at least say that in this case we had one.

For over the 10 years, our estimate is it will be half a billion dollars.

The Chairman. All right. Senator Kyl.

Senator Lincoln. Five hundred million over 10?

Mr. Lieberman. Ten years. Yes.

Senator Lincoln. All right.

Senator Baucus. We appreciate that very much. Thank you.

The Chairman. Senator Kyl.

Senator Kyl. Thank you, Mr. Chairman.

Senator Snowe and I were commenting a minute ago that you and Senator Baucus are going to be very busy working with all of the Senators over the weekend and we appreciate that.

There is a serious matter that I want to bring to the attention of the committee that is going to require work, perhaps not over the weekend, and the next two weeks, but we have got to address it sometime soon. And it is my Amendment #6 to the Chairman's mark related to the Medicare Payment Advisory Commission demonstration projects for payment of position services.

This amendment would try to begin to fix the Medicare reimbursement rate for physicians. Currently, calculated under a formula using the sustainable growth rate or affectionately referred to as the SGR. That

expenditure target is predicted to reduce payments to physician and other healthcare professionals by 4.2 percent in 2004, 4.2 percent. With additional cuts projected in 2005, 2006 and 2007.

And with the costs for physicians and others increasing, as all of us know they are, this is clearly unsustainable. We will be lucky to have half of the positions available to serve out Medicare senior patients by 2006 if all of this transpires. So what to do?

Well, this amendment will establish a two year MedPAC demonstration. In the first year, there would be a 2.5 percent update in the 2004 physician/practitioner conversion factor. And in 2005, the update would be equal to the increase in the MEI, or the medical economic index. Those two years we would see what the increase would be. And then there would be a return to the SGR determined targets in 2006.

While we cannot do this right now because we do not have a score and there would be some score in the years 2004 and 2005, the reality is that over a 10-year period, the physicians would actually pay for this because we would return to the SGR determined formula in the year 2006.

Let me just describe the need for this. Everybody knows about the increase in medical malpractice premiums,

the increased cost of practice from HIPAA regulations, the inflation in every respect a physician's office with his personnel and equipment and all of the other things.

And yet, as I said, the projected rate for next year is 4.2 percent cut. It does not make sense. And there is a reason why there is a flaw in the formula. But we have got to do something to change that formula.

Let me just reflect a little bit more history. I mentioned the 4.2 percent cut in 2004. This would actually be the fifth cut since 1991 and would be on top of a 5.4 percent cut in the year 2002.

From 1991 to 2003, the payment rate for physicians and health professionals fell 14 percent behind practice cost inflation as measured by Medicare's own conservative estimates. So clearly, there is something wrong.

Well, what is wrong with the SGR expenditure target? The problem is it is linked to gross domestic product and penalizes physicians and other practitioners for volume increases that frequently they cannot control and that the government actively promotes through new coverage decisions, quality improvement activities and other initiatives that while beneficial to the patients, are not reflected in the SGR.

So there is a problem and we ought to change it. And I think at least, we can begin on the solution with

the amendment that I have offered because it would temporarily implement the MedPAC recommendation to Congress that annual updates in physician payments should reflect increases in the Medicare economic index, the MEI. That is the real index we ought to be using.

Specifically, as I said under the amendment, there would be a 2.5 percent update in 2004. And then the 2005 factor would be an update equal to the increase in the MEI for that year.

Let me just quote to you from one article that further illustrates the problem. I think many members know Robert Moffitt of the Heritage Foundation who wrote an article. And he talked about this problem reaching the breaking point, particularly in Denver and Seattle. He said, "In Denver, only a third of the doctors say they will accept new Medicare patients." That is down 52 percent in 2001. A rate of decrease that has been called alarming by other experts.

In Seattle, the percentage of doctors who accept new Medicare patients fell 71 percent to 55 percent in four years. Gaining access to doctors, particularly specialists has become increasingly difficult for seniors.

There is another report that indicates that seniors are willing to wait far longer to see doctors for check

ups and even for specific illnesses, that the proportion of physicians who accept all new Medicare patients is falling from roughly 75 percent to about 71 percent in just four years and that the percentage of surgeons willing to operate on new Medicare patients is falling faster still from 85 and a half percent down to 73 percent in the same period. Why? He concludes, "Medicare controls its costs by limiting benefits and setting artificially low fee schedules for the services that it covers."

Senator Hatch. Would the Senator yield on that?

Senator Kyl. Absolutely, Senator.

Senator Hatch. Let me tell you, I think the Senator is right. And I have had a lot of doctors from my home state of Utah come in and say it just is not right. It is not fair. They do not want to handle Medicare anymore because it is just not worth all the paperwork hassle and everything else. And the reimbursement levels are so low.

So I am willing to work with the distinguished Senator to see if we can bring about some sense in that. And I am sure others on this committee will be, too. So I just want the Senator to know I think he is making a very good case and I agree with it 100 percent. Because I think something has to be done now.

Senator Kyl. Thank you, Senator Hatch.

I appreciate that. I would just conclude by saying we are all aware of this problem. The rates are set unrealistically low. The cuts occur. We hear the stories about physicians and others not wanting or not being able to treat Medicare patients.

The cost gets to be so great that every couple of years, what are we asked to do? We are asked to pass an enormous, what is called, "Give Back Bill" that tries to compensate for these reductions to keep these practitioners providing care to our seniors and to the rest of us, frankly.

Somehow or other we think these artificially low limits are achieving something. All they are achieving is a horrible disruption in the market and in the treatment of our seniors and other citizens.

Senator Bunning. Mr. Chairman?

The Chairman. Senator Bunning.

Senator Bunning. I would like to comment and complement the Senator from Arizona on his amendment. We have experience not only in West Virginia, my neighboring state, but Kentucky has experienced doctors who went on strike, refused to take Medicare patients and refused to service anyone.

Not only the medical malpractice way out of whack,

but the reimbursement under Medicare is outrageously small and getting smaller. And we ought to do something. And your amendment at least makes an attempt to take care of, at least in 2006. I think it is going to go beyond that.

If we go back to the same kind of cuts that are projected down the line. So I would support your amendment and hope that this committee would support it.

Senator Kyl. Thank you very much, Senator Bunning.

I think this will have a lot of support from all around. We just simply lack a score and there is no money "available" in this bill for 2004 and 2005. So we have got to find it.

We have got to figure out where it is available and how we can adopt a demonstration project like this or something similar to begin to resolve this problem. And Mr. Chairman, I know that you have got a lot of commitments to work with us all on a lot of different things, but perhaps as soon as we can finish this bill on the floor, you can the others who have expressed an interest in this, and I and others could get together and figure out how we can approach this problem legislatively so that we do not continue in this cycle, which is eventually going to result in deteriorating medical care for us all.

Senator Hatch. Mr. Chairman, I wonder if we could ask Mr. Scully what he thinks about this, what the costs will be et cetera. I think it is a really important issue. It is something that all of us are worried about.

And I have got to admit, the medical profession has been drastically changed to where doctors are constantly under pressure with medical liability and litigation and unnecessary defensive medicine, et cetera, to the point where our costs are going out of sight.

The Chairman. I would like to have you also tell us in the process who the bureaucrat was that told us that when we appropriated that $54 billion in January as part of the omnibus bill to take care of that last cut that also said that whatever we did, then and if whatever we did, who knows what we did, but that was going to take care of and fix the formula forever. Now, here we are right back probably with another $54 billion and another $54 billion over the next four years. I would like to know who that was. They convinced the House of Representatives that this was just as easy as pie in the sky.

Mr. Scully. Mr. Chairman, I will take the heat for that.

The Chairman. Oh, you are the bureaucrat?

Mr. Scully. I am the bureaucrat.

The Chairman. Well, I heard that there is some actuary down there that we do not know who he is anymore.

Mr. Scully. That is the chief actuary and he is not here. He is probably happy he is not here.

The Chairman. Well, I would like to meet him and ask him how come he told us that they could fix it for $54 billion and we fixed it for $54 billion and it is not fixed.

Mr. Scully. Mr. Chairman, one of the problems of this whole thing, in 1997, to go back to the history of how this happened, if you remember we did big cuts or baseline reductions to hospitals, to nursing homes, to all kinds of people. But in 1997, we did very little physicians.

And the reason that happened is that the physician groups and the Congress agreed to really tighten up the formula so we have very little discretion, which is how we got in the hole last year.

The formula has almost not discretion at all. And what happened was when they made the snapshot in time last winter, the economic estimates were different, they did think it was going to fix the hole for a number of years, but the SGR formula is so restrictive that when the economy continued to go down, the numbers changed.

We also found that when they had the two years ago

physician volume, which was supposed to go up two percent a year, it went up eight percent a year, he does not have any discretion.

The Chairman. Let me tell you, you convinced some of the smartest Congressmen in the other body that this was going to take care of it forever.

Mr. Scully. We thought it would, at the time. And believe me, I believe the formula needs to be fixed comprehensively, but it is expensive. I mean, the physicians avoided similar cuts that other providers took in 1997 by coming up with an extremely restrictive formula and it has basically blown up on them.

Senator Hatch. We need your help in changing it because, my gosh, the physicians are dropping these people like flies. And we have got to get where Medicare people are taken care of.

Mr. Scully. Well, Senator Kyl's approach, and I think Steve would agree, that the good news about CMS is on the existing program, we are usually within about a half a percent of each other and our scores are almost identical.

On the existing program, which the physician payment is part of, we do have a score. And I think Steve's are probably very, very close. And over 10 years, Senator Kyl's amendment actually probably saves about $1 billion,

1.5.

Of course, it costs 5.2 over the first five and you have a scoring problem the first couple of years, but it is basically a band-aid. It pushes the problem out. You would have a plus 2.5 percent update for the first two years, but in 2006 it would be -5.3, 2007 -5.4.

So it creates a huge cliff. That is a band-aid for two years and creates an enormous problem thereafter. So if the goal is to push it out--I just do not want to mislead anybody here--you are pushing the problem out and you are making the hole much deeper.

It will solve your problem for two years. And it may well be the cheapest short term way to fix it, but it definitely just makes a bigger hole when you get to 2006.

The Chairman. Senator Frist?

Senator Frist. Thank you, Mr. Chairman. I want to turn to an amendment. We have completed the discussion on the last amendment? My Amendment #8, and I was going to mention it shortly, but it has to do again with the fall back position that we were talking about about 30 minutes ago.

I want to introduce this concept and I hope that the managers will give it real consideration. Again, it is an issue that has not been addressed over the course of the day, but it comes back to how much we should depend

on this hard fall back position.

Neither in the tripartisan plan from last year, nor in the House past plan from last year was there such a hard fall back. And by that I mean a fall back if we do not have two plans to a government-run program that would be offered through an entity that does not share risk, which was the point that Senator Santorum was making earlier.

My concerns with that, not that we should not have a fall back, but I want to make that a true last resort, are twofold. And we have touched both of these points over the course of the day.

First, based on previous analysis by CBO, we know that private risk bearing, risk-bearing insurance plans can provide more cost effective coverage of prescription drugs. And CBO has said that earlier today. And that being the case, I am very hesitant to rely upon a government-run program that has absolutely no risk.

The second issue is that one of my goals for this legislation is indeed to allow consumers through market forces to establish the proper price for the healthcare services that are received, that is, instead of having price controls or fixed prices, prices set by government.

Thus, my amendment really inserts another option at the discretion of the administrator. Between the two

plan consideration and then come dropping all the way down to a hard fall back government run, which would set prices.

My amendment would buffer those two by allowing the administrator, not requiring the administrator, to have one additional option and that would be to contract the standard benefit with a risk-bearing insurance plan that already has a proven track record, and that would be a plan that is in the business of the Federal Employees Health Benefits.

So, thus, if we do not have two private plans in an area willing or able to offer prescription drug coverage to Medicare beneficiaries, the amendment would allow the administrator to enter into an arrangement for the provision of such coverage with the risk-bearing health insurer that is already providing coverage through the Federal Employee's Health Benefit plan as long as that network or that non-network plan were willing to enter into such an agreement.

Again, my reasoning comes that I am hesitant for the reasons that I outlined earlier to say let us go to that hard fall back and thus want to give the administrator that opportunity to reaching out to the FEHBP plans which are already in the area as a risk-bearing entity to provide those services.

The goal of the amendment is important and that is we should not rush to the fall back position. There are significant risks, I believe, in relying totally upon the government.

We have seen that with Medicare that if you have the government offering benefits like Medicare today, over a period of time, it does not adapt with the times as well. So I wanted to offer this amendment. I know we talked a lot about the fall back earlier and have the managers consider that as we go forward.

The Chairman. Thank you. We have one more member that wants to offer an amendment and then we will go to final passage. And I would like to remind everybody that after we vote on this, I do not think it will take long, but we have got to do the SCHIP Bill. Senator Bingaman.

Senator Bingaman. Thank you, Mr. Chairman. I will do this quickly. But I have an amendment, a modification of my Amendment #1 that I have distributed. I think everybody has got a chart. It is called Bingaman Amendment #1 Modification. It relates to the assets test. And I would just like to explain it and get the Chairman's reaction to it.

The assets test, I think is an unfortunate provision that remains in the law under the Chairman's mark. What essentially it says is that if you have $4,000 worth of

net worth, then you are not eligible for the same low income benefits that you otherwise would be.

Or if you are married and you have got $6,000, the couple has $6,000. So if you have got a car with a blue book value of $4,000 and you have got $2,000 somewhere, then you fall into a new category, which means you have got to pay higher copays than you otherwise would have to under the law.

The Chairman's mark provides that no matter what your income level, it could be 50 percent of poverty, it could be 25 percent of poverty, it does not matter how low it is, no matter what your income level, if you fail the assets test, you are required to pay 10 percent copay up until you get into the doughnut and then 20 percent copay above that until you get into the catastrophic. And you also have a $50 deductible.

To my mind, that is too much for the very low income individuals. And my amendment, what I am proposing here is to say that if your income is 100 percent of poverty or less, or less than 100 of poverty, we should reduce the amount of that copay that you are required to make even if you fail the assets test.

Instead of 10 percent and 20 percent, I would propose we reduce it to 2.5 percent and five percent. And then if you are above the 73 and 3.7 percent of

poverty, have it at five percent and 10 percent.

Now, this chart goes into that in some detail. I would be glad to go through it in any more detail anyone wants. Frankly, I think the preferable course would be to just eliminate the asset status, but I am informed that that would be expensive. And this is a modest change for those people that have less than 100 percent of poverty--their income is less than 100 percent of poverty.

I think this would be a reasonable change. And I would hope that we could get a score. I do not know if CBO, we gave this to them on Monday to look at. I do not know if they have got a score back. I guess they do not. I would be anxious once we get a score if the Chairman would be willing to look seriously at this amendment and consider incorporating something like this in the final bill.

The Chairman. I would be willing to visit with you about it and consider it. But I suppose an overriding thought I need to give you, because we did give some consideration to what you are asking.

At the same time, we also had the whole plan did not score as high and we had a little bit of extra money and we opted to have a better benefit program. And so we did that by raising it from 150 percent of poverty to 160

percent of poverty. And we felt that that was a better way of doing it.

Now, I do not say that to satisfy you, but at least our hope is you know that we gave some thought to various trade offs and we decided that this was the best place to invest some money, between 150 and 160 percent of poverty.

Senator Bingaman. Well, Mr. Chairman, as I say, for this group that has incomes of less than 100 percent of poverty, I would hope we could go back and just look at whether or not this assets test has an unreasonable impact on their copays. As I see it, it does.

I think you are talking about people with very, very modest resources being told that they have got to pay 10 percent of their prescription drugs and then 20 percent of their prescription drugs when they get above the doughnut. If you get very low income individuals with very high drug costs, this becomes a very substantial burden if they fail this assets test. And I think we should try to find a way around that if we could.

The Chairman. All right. Senator Breaux.

Senator Breaux. Thank you, Mr. Chairman. Mr. Chairman, my amendment is listed as Breaux #2. And this generically could be called the Functional Equivalent Amendment.

And basically, my amendment would say that the secretary shall not publish regulations prospectively in the future. It is not retroactive, which would adopt or apply a functional equivalent test or a similar standard in order to deem a particular drug or a biological to be identical or similar to another drug already on the market for the purpose of limiting or reducing payments.

The amendment does not in any way restrict any other authority that the secretary has in order to go about reaching cost containment on drugs and how we pay for drugs.

I have a list of about over 50 groups and organizations representing patients and biological groups and organizations as well as medical schools like the letter from LSU medical school says, "We are concerned that what happened was that CMS established a new standard which they call the functional equivalent test to determine if a new product was eligible for reimbursement and what rate that it would be reimbursed at.

They believe, and I think it is correct to say that if you are going to say that a new drug that has come on the market is the same drug as some drug that is already there.

That should not be a decision made by the

bureaucracy, the agency that determines prices, but should be made by the agency like the Federal Food and Drug Administration, FDA, who makes that medical determination.

So my amendment would simply say that prospectively only, they could not use this term which is found nowhere functionally equivalent or a similar type of standard to reduce reimbursement payments. It does not, again, affect any other authority that you have in order to bring about cost containment and the reimbursement of pharmaceuticals.

The Chairman. I think at this point I would like to ask for the question. Those in favor, say aye.

[Chorus of ayes]

The Chairman. Opposed, say no.

[No response]

The Chairman. The ayes have it. The amendment is adopted.

Senator Lincoln?

Senator Lincoln. Thank you, Mr. Chairman.

The Chairman. And I think you have the last one. And Senator Daschle has asked to make a short statement.

Senator Lincoln. Yes, sir.

The Chairman. So, when you are done, we will go to Senator Daschle and then we will vote to pass the last

one.

Senator Lincoln. Yes, sir.

I just want to complement you, Mr. Chairman, on working with the rural ambulance providers. The five percent bump that is included in the package would add approximately $10 per transport for providers in States like New York, perhaps.

But it is really not nearly enough to sustain the operation of, for instance, three of our ambulance providers in Arkansas that are scheduled to close as of July 1.

And I would just would like to ask the committee, Mr. Chairman, you have done such a fabulous job in the rural health caucus along with Senator Thomas and Senator Conrad. And there is a bill introduced by Senator Dayton that is included in the rural healthcare package. And I hope that we can work together to see if we cannot come closer to something like that that is going to do a better job at dealing with our providers.

As you know, these ambulance services are required to maintain the same service with fewer reimbursements. So I just hope that we can work together between now and then.

And would also like to just ask that--we visited with both your staff, you and Mr. Scully about the GME

for the second year on geriatrics. We have provided it in language. The Chairman has provided language, Mr. Scully, and I hope that is going to be enough. Can you give me some indication that that is going to be enough for you to be able to move forward on that?

Mr. Scully. Senator Lincoln, I think we could definitely fix it. I basically need language since our House rules are already out for the year. Their language said that we could do this without notice and comment, then I can fix it in this year's rule.

Senator Lincoln. The Chairman has obliged with that, so I just wanted to make sure that was all right. Mr. Chairman, you have been very kind. Thank you very much.

The Chairman. Thank you.

Now, Senator Daschle.

Senator Daschle. Well, Mr. Chairman, I am sure I speak for the whole committee in congratulating you and the Ranking Member, Senator Baucus for the outstanding way that you have conducted this mark up throughout the day. I think it has been fair. It has accommodated everybody. And while the outcome may not have been as we would have liked in some cases, I think you have done an outstanding job.

Many of us who have worked on this issue for a long

time have struggled with the decision on how to vote on this bill. And I remain, frankly, very concerned about many of the aspects of this plan.

I think some of its shortcomings will probably be even more apparent in the not-too-distant future. But I do appreciate the many improvements that have been made, especially the rural provisions. The effort that you have made to reduce the coverage gap. I think those are significant changes in the legislation.

I think it is a start, however shaky we may view that start to be. And I think it is an important opportunity to create a prescription drug benefit under Medicare, which is what your efforts have been.

I think we have got to continue to work to make this bill better. I am still hopeful that over the course of the next couple of weeks on the floor we can do just that. And you have assured many of us that you will work with us as we have come up with ideas. And I look forward to working with you to make that happen.

By reporting the bill out of the committee, we are going to be in a position to allow that effort to improve this legislation to continue. And so therefore, I intend to vote aye on the legislation.

The Chairman. I thank you very much for that statement and for your helping us move this bill along.

I would now ask that the Chairman's mark, as amended, be adopted. Those in favor, say aye.

[Chorus of ayes]

The Chairman. Those opposed, say no.

[No response]

The Chairman. The ayes seem to have it--do have it. And the amendment is adopted. I would now ask that the committee favorably report S-1, as amended. And I would ask for the A&As and ask the Clerk to call the roll.

The Clerk. Mr. Hatch?

Senator Hatch. Aye.

The Clerk. Mr. Nickles?

Senator Nickles. No.

The Clerk. Mr. Lott?

The Chairman. No, by proxy.

The Clerk. Ms. Snowe?

Senator Snowe. Aye.

The Clerk. Mr. Kyl?

The Chairman. Aye.

The Clerk. Mr. Thomas?

Senator Thomas. Aye.

The Clerk. Mr. Santorum?

The Chairman. Aye.

The Clerk. Mr. Frist?

Senator Frist. Aye.

The Clerk. Mr. Smith?

Mr. Smith. Aye.

The Clerk. Mr. Bunning?

Senator Bunning. Aye.

The Clerk. Mr. Baucus?

Senator Baucus. I am an Aye.

The Clerk. Mr. Rockefeller?

Senator Baucus. No, by proxy.

The Clerk. Mr. Daschle?

Senator Daschle. Aye.

The Clerk. Mr. Breaux?

Senator Breaux. Hallelujah. [Laughter].

That is an aye.

The Clerk. Mr. Conrad?

Senator Conrad. Aye.

The Clerk. Mr. Graham?

Senator Baucus. No, by proxy.

The Clerk. Mr. Jeffords?

Senator Baucus. Aye, by proxy.

The Clerk. Mr. Bingaman?

Senator Bingaman. Aye.

The Clerk. Mr. Kerry?

Senator Kerry. I will temporarily pass.

The Clerk. Mrs. Lincoln?

Senator Lincoln. Aye.

The Clerk. Mr. Kerry?

Senator Baucus. Kerry is no, by proxy.

The Clerk. Mr. Chairman?

The Chairman. Aye, of course.

The Clerk. Mr. Chairman, the tally is 16 ayes, five nays.

The Chairman. The bill is reported. Would you please wait so we can get the SCHIP Bill out? Well, wait. I have got some unanimous consents here to finish up. The bill is obviously favorably reported.

I would further ask that the staff have the authority to draft necessary technical and conforming changes to the Chairman's mark, including those needed to comply with our budget requirements. Without objection, so ordered.

[Whereupon, at 8:29 p.m., the meeting was concluded.]

Statement of the Honorable Orrin G. Hatch
on
The Prescription Drug and Medicare Improvement Act of 2003
Senate Finance Committee
June 12, 2003

MR. CHAIRMAN,

Thank you for letting me proceed now. As you know, we have a markup session in the Judiciary Committee which I must chair. I hope to return shortly.

Let me abbreviate my remarks and ask permission to submit the rest of my statement for the record.

First, I want to extend my congratulations to both you and Senator Baucus on a job well done. This is a landmark occasion for everyone, especially Medicare beneficiaries across the country.

Seniors have been waiting for the last 38 years for a comprehensive and permanent Medicare prescription drug benefit. Well, I'm here to tell America's seniors – they won't have to wait much longer because help is on the way!

Last year, we worked so hard to pass a drug benefit for our seniors.

The Tripartisan group – you, Senator Snowe, Senator Jeffords, Senator Breaux and I -- spent a year and a half writing our bill. We met day and night to discuss policy and we talked to many individuals and organizations which were interested in the Tripartisan bill. It was an incredible year and a half for me – I was proud to be a part of a process aimed at helping so many elderly and disabled Americans.

We came so close to having our prescription drug legislation passed by the Senate last year. But, unfortunately, partisan politics got in the way. However, I do not believe that our efforts were in vain. Rather, I believe that the Tripartisan Group laid the foundation for the bipartisan bill that is being considered before the Finance Committee today.

Mr. Chairman, you and Senator Baucus deserve credit for a job well done. This legislation is even better than the Senate Tripartisan bill from last year because it encompasses several important principles.

It offers beneficiaries a benefit through the private sector, with reasonable and fair cost-sharing. The beneficiaries have the ability to obtain the drugs of their choice without government interference and with better coverage choices.

Last year's bill only offered beneficiaries a stand-alone drug benefit. The bill we have before us today provides beneficiaries with several choices – a stand-alone drug benefit, a drug benefit through a PPO or a drug benefit through an HMO.

And, before the drug benefit is implemented on January 1, 2004, beneficiaries will be offered a prescription drug card which could reduce the price of all prescription drugs, not just those that will be covered by the plan, by as much as 25 percent.

Another important improvement is drug plan access to rural areas. Last year, there were many concerns about whether or not private drug plans would be willing to offer coverage to beneficiaries living in rural areas. Over the last six months, we have worked hard to address this important issue. I am pleased to say that we have made significant progress in this area and improving this provision helps my home state of Utah.

The bipartisan Finance bill creates at least 10 regions across the country to provide prescription drug benefits to seniors. These regions would have to be at least the size of a state which helps states like Utah that have both urban and rural areas. Beneficiaries living in a region must be offered the choice of at least two drug plans – each having the same monthly premium. And, the Finance legislation also includes a fallback drug plan for regions in which fewer than two drug plans are offered to beneficiaries.

It also reforms the Medicare program by providing beneficiaries choice in health coverage. If seniors wish to remain in traditional Medicare, they may do so. If seniors want to keep their Medicare+Choice plan, they may do so. If seniors want to enter into the new PPO option, which is modeled after private health insurance, they may do so. There are choices for everyone.

The Finance plan also provides more generous coverage for low-income beneficiaries by giving assistance to those who are below 160 percent of the federal poverty level. One of my primary goals is to provide additional assistance to those who need it most and are struggling to pay for their prescription drugs.

And most important, the process for the consideration of the Finance Committee's prescription drug bill has improved dramatically. The legislation is supported by both the Chairman and Ranking Minority Member of the Senate Finance Committee and will be supported by a majority of the Senate Finance Committee members.

Under your leadership, Mr. Chairman, we have had a hearing on this bill and we will mark-up this legislation in Committee today before we go to the Senate floor. What a difference a year makes!

In conclusion, passing this legislation is the right thing to do for our seniors. I am so proud to have played such an important role in making this dream a reality for Medicare beneficiaries across the country. This is a historic day for the Senate Finance Committee.

Statement of Senator Olympia Snowe
Finance Committee – Medicare Rx Drug Benefit
June 12, 2003 - Final Statement for Record

Thank you, Mr. Chairman. I want to commend you for your *unwavering* commitment to reaching out and forging a bipartisan consensus so we can move this critical legislation this year. The President rightfully issued the charge to have a bill on his desk in July...our Majority Leader has shown *tremendous* leadership in establishing a timetable and providing ample floor time to make the process work...and let me also thank Senator Baucus for his dedication and willingness to reach across party lines to forge an agreement.

Margaret Thatcher once said, "You may have to fight a battle more than once to win it." Well, I've been fighting this battle now for five years – but I believe with this bill we *will* finally enact the most monumental change to Medicare since its inception in 1965. We're a *far cry* from where we started -- from a reserve fund proposed by President Clinton for a Medicare drug benefit, to the $40 billion, 5-year reserve fund Senator Wyden and I carved out in the Budget in 2000, to the $370 billion, 10-year tripartisan plan I helped develop last year, to $400 billion now, as proposed by the President. And the *policies* in this consensus bill certainly weren't achieved in a vacuum – they are the direct descendant of the Tripartisan bill and the apogee of an *evolutionary* process of numerous iterations and *ceaseless* vetting.

It has been a healthy competition of ideas that has brought us to this day – recognizing it's *impossible* in a 51-49 Senate to design the largest domestic program in nominal terms *ever created*...to pass the most significant enhancement to Medicare in its 38 year history...with a "my way or the highway" approach. Concessions must be made, and thankfully they *have* been made – because we *cannot* hold hostage our seniors' futures to a political unwillingness to compromise.

The bill is a culmination of five years of bipartisan bridge-building, and of invaluable lessons that have only *underscored* the principles I've fought for in

legislation and countless negotiations throughout this process – that, in keeping with the basic tenets of Medicare, benefits be universal...permanent...sustainable... affordable...and *equal* across all plans while targeting the most assistance to low-income seniors.

For those who have said, "we need a meaningful, *reliable* benefit", this bill provides a solid foundation for achieving that goal. I know some would ultimately prefer a fully *government-run* system. But we now have the benefit of learning from last fall's debate that it would cost more than $600 billion over ten years, according to a preliminary CBO score – and up to a trillion by other estimates. And such an approach would have significant restrictions. *That* bill – which also sunset after seven years to mask the true costs – *statutorily limited* the number of drugs a senior could purchase within a therapeutic class to just two.

In contrast, the bill before us is a consensus-driven benefit that is universal, does *not* expire, and does *not* place government limitations on the number of medications. Moreover, according to CBO, combining traditional "fee-for-service" with options for enrollment in private, "risk-based" plans could keep costs down – *all the more* critical with 77 million baby boomers beginning to retire in 2013. Now, I recognize some of my colleagues believe earnestly and in *good faith* there should be more incentives to encourage seniors to move into private plans. But in *my* view, particularly with the huge disparity between CMS – which predicts 43 percent of seniors would participate in private plans, and CBO, which estimates a *two* percent enrollment rate – *and* with the upcoming strain imposed by retiring baby boomers, we ought to take the more cautious approach of this bill.

Seniors *should* have the *option* of staying where they're *comfortable – without* sacrificing guaranteed *and* equal prescription drug benefits. Again, we don't really *know* how these plans will work. So *priority one* is extending both security *and* fairness into the program, and we do it by ensuring *all* plans will offer actuarial equivalent benefits. At the same time, seniors should *also* have the choice of trying

the newly-created private options insurance companies have said they would offer under this bill, *without* undermining the traditional fee-for-service "safety net" that has a proven track record.

Others have criticized this plan for not having a *defined benefit.* But do we really want a "one-size-fits-all approach"? Are we really prepared to *pay* for such a government-run program, as we've seen – and to say to seniors, you won't have *choice?* As enrolles in FEHBP –called "a highly promising model for Medicare" by one witness last week, *we* have choice – it works for *us.* And for those who say that's different because FEHBP enrollees are younger, *actually* the average age is *61* – and if FEHBP can control costs for a relatively older group – that are *also* proven higher utilizers of care – shouldn't we see if this *is* a good model for Medicare? With this bill, seniors can *select* from a variety of offerings *secure in the knowledge* those plans include *benchmark standards* this bill *requires* to ensure overall quality of coverage.

We *also* address the concerns of those of us from rural states that *some* areas could be left without a private-market plan by incorporating new risk management mechanisms – most significantly, requiring plans to bid regionally which will meld urban and rural areas – to further enhance the opportunity for plans to *participate* in rural regions. And building off last year's debate, we have determined the *federal government* will provide a fall-back plan that is both *guaranteed and seamless.*

Because access must *never* be segmented by zip code – and neither, frankly, should the cost of premiums. And I'm concerned that while this bill is a good start, it doesn't go far enough because there may end up being variations among regions for the cost of the premium. So I intend to offer an amendment to ensure the premium is level and *affordable*, no matter where you live in the country.

Finally, we have *improved* on the Tripartisan bill by using the eligibility criteria under existing Medicare low-income assistance programs to target the *most* help with premiums, deductibles and co-payments to those nearly 4 million seniors

Statement of Senator Olympia Snowe
Amendment to Establish a National Rx Drug Premium
June 12, 2003

Mr. Chairman, thank you for allowing me to offer this amendment, which I believe will enhance the already solid foundation provided in this bill by ensuring fairness in premiums from region to region. I also would like to thank Senator Lincoln for joining me in this effort – we have worked together in the past to enact good policy, and this issue is no different.

One of the basic tenets of the Medicare program is to provide health care benefits to seniors and persons with disabilities for the same price, no matter where they live. So whether you are a senior living in Phoenix, Arizona or Portland, Maine, you will pay the same $58.70 for your Part B premium. Therefore, as we embark upon this historic venture to finally enact a prescription drug benefit, I strongly believe we should continue to adhere to this traditional, established and tested principle of the Medicare program.

The fact of the matter is, access to care and the cost of premiums must *never* be segmented by zip code. So while I have strongly endorsed this bill, I am compelled to offer this amendment that will ensure that premiums for the new prescription drug benefit will be *affordable*, no matter what your address. The amendment achieves this goal by providing the Secretary of Health and Human Services with the authority to adjust payments to plans to help minimize variations in costs across regions.

I know some will argue that beneficiaries living in states where costs are cheaper and utilization of prescription drugs may be lower should not subsidize those living in high cost areas, or where people may have a higher drug utilization rate. But we need to keep in mind several critical factors.

We need to recognize how disparities in premiums from area to area could lead to instability for seniors enrolled in private plans. Just consider the case of Medicare+Choice – premiums in some regions of Florida are at $16 a month, while in Connecticut they're *$99* a month. Just from a basic standpoint of fairness, do we really want to create such a system for seniors with their drug coverage? We need a level playing field so seniors will have some degree of certainty. How do we explain to seniors in New Hampshire they're paying a considerably different amount than their neighbors just across the river in Maine?

But that's not the only way in which we need a level playing field in order for this new program to succeed. As others have pointed out, how can we – and how can *seniors* – find out if private plans are superior to fee-for-service if there are wild fluctuations and disparities between plans and the traditional benefits? Moreover, premiums would likely change *every year.* Seniors could move to different – and more premium-friendly – regions causing utilization to go up and a corresponding upward swing in premiums. The bottom line is, so many of those in these plans will be on fixed incomes – but there will be nothing fixed about their premiums and with the potential for wild fluctuations, they simply won't take advantage of the very plans we're trying to *create* in order to ensure they can afford their prescription drug needs.

Mr. Chairman, with the traditional Medicare program now serving nearly nine out of every ten beneficiaries, shouldn't these seniors not have to worry about the fine print of premiums? Shouldn't they already have stability, as they have with Part B premiums? We're going for a universal benefit here, let's provide a universal premium seniors can rely on, rather than engaging in guesswork – let's provide them with truth-in-advertising, so they will know that when it comes to premiums, what they see is actually what they will get.

with incomes below $11,943. And unlike Tripartisan, assistance will be provided *without an asset test* to the approximately 17.5 million seniors under *160 percent* of poverty or $14,368 per year – nearly half of all Medicare beneficiaries.

***At the same time*, we ensure those under 160 percent will *never be subject to a gap in coverage*, where they would be responsible for 100 percent of the cost. I would have preferred to eliminate the gap in coverage for those over 160 percent but CBO states it will cost more than $200 billion to do so. We should examine ways in the future to remove this gap in coverage. We should *also* consider that nearly 88 percent of *all* seniors spend under the $4,500 threshold to the so-called "donut" –and that's *before* counting the supplemental coverage many have that could keep even *more* seniors below the donut. *Moreover*, it may *also* be likely that, as with FEHBP, plans under this bill will tailor benefits and offer options that don't include a gap.**

The bottom line is, with the cost of prescription drugs having increased by 16 percent between 1999 to 2002 – a rate seven times higher than the rate of inflation – we are *beyond* any question of need. And when you consider 20 percent of Medicare beneficiaries have 5 or more chronic conditions and account for 63 percent of total program spending – and most such conditions are treated with prescription drugs – shouldn't our goal to be enroll all seniors – *especially* those with chronic conditions, in a comprehensive prescription drug program?

This bill, *while not perfect*, is a concrete and meaningful foundation on which to build for the future. Now, we need to decide whether or not we want to play politics or pass *policy*. Let us be able to look back on this day as proof that solutions can win out over sound bites...let us pounce on this window of opportunity...let us surmount the political hurdles and travel this last mile in carrying Medicare forward into the 21st century. Thank you, Mr. Chairman.

Opening Statement
Senator John Kerry
Medicare Mark Up
June 12, 2003

We are here today to address the hopes of every senior in America who is counting on us to put the politics aside, roll up our sleeves, make hard choices, and do what is necessary to add a comprehensive, affordable, and guaranteed prescription drug benefit to the Medicare program. It is past time. It is a monumental task before us and we have a moral imperative to deliver its promise.

I commend Chairman Grassley and Senator Baucus for putting forward their best effort at bringing us to a reasonable starting point.

There are many things I like about the underlying bill: a rejection of the President's desire to force seniors into private plans; a rejection of the

President's plan to disadvantage seniors who want to stay in traditional Medicare and keep their same doctors; a rejection of the President's plan to give a windfall of incentives to PPOs to encourage their participation in the program; and an adoption of long-standing Democratic principles that include significant cost sharing protections for low-income beneficiaries, a guaranteed fallback plan, and some key efforts targeted at improving the traditional fee for service benefits under Medicare.

However, there are also many areas that need improvement: the gaps in coverage in the doughnut hole should be filled; seniors shouldn't be charged premiums when they aren't receiving benefits; there should be adequate protections to ensure that employer coverage is not substituted or dropped; we must improve the stability of the

fallback plans to minimize confusing and inconveniencing seniors; we should be more equitable in our support of provider relief by including some help for urban hospitals as well; we should try to eliminate the new increases in beneficiary cost sharing under traditional Medicare and be more aggressive about providing additional benefits under the program.

But, my colleagues, we are in a straightjacket today. We are bound by the constraints of a number that was essentially plucked out of thin air as the upper limit of what we could spend to design a drug benefit. Plain and simple, $400 billion isn't enough money. And we shouldn't settle for it. No matter what way you slice it, no matter how you design it, $400 billion for more than 40 million beneficiaries automatically means that there will be gaps in coverage, a skimpy

benefit, or both. This is George W. Bush's number, not ours. When something is important enough to the Congress, we always find a way to pay for it. By my estimation, we need at least another $150 billion to do this plan right. We must stand for more and fix what is wrong with this proposal.

Statement of Aníbal Acevedo-Vilá,
Resident Commissioner from Puerto Rico and
Member of Congress, before the Senate Committee on Finance
June 12, 2003

Mr. Chairman, the Commonwealth of Puerto Rico, like most states of the union, is confronting a number of challenges as it strives to provide quality health care to its 4 million citizens. Our local government is committed to strengthening the health care system. In fact, the Commonwealth finances approximately 85 percent of the costs of Medicaid in Puerto Rico, a burden no other jurisdiction has and one that is becoming unbearable. For us to move forward, it is essential that the Federal government be an active and strong partner in this endeavor. As Congress creates a prescription drug benefit and enacts Medicare reform, I urge all Members of the Committee to ensure that this legislation addresses the needs of U.S. citizens living in Puerto Rico.

Since its inception, Medicare has provided healthcare for seniors living in Puerto Rico. Therefore, it is essential that beneficiaries living in the Island have access to the same level of prescription drug coverage under the same terms and conditions as is offered to all others throughout the country. In addition, any Medicare prescription drug program must provide adequate subsidies for low-income beneficiaries in Puerto Rico as in all other U.S. jurisdictions.

Puerto Rico's workers and employers pay their full share of Social Security and Medicare payroll taxes to the federal government. Limitations on the benefits or subsidies that have no foundation in healthcare policy but are based on geographic location would fail the fundamental goal of providing uniform Medicare benefits to all seniors.

The second issue that I ask this Committee to address is the payment to hospitals in Puerto Rico. While all U.S. hospitals receive a 100 percent federal payment, hospitals in Puerto Rico receive only 50 percent through a special formula. No other jurisdiction receives this type of treatment under the Medicare system. Our hospitals currently operate under extreme financial constraints, and some have even decided to withdraw from the Medicare program.

Again, U.S. citizens in Puerto Rico pay the same federal payroll taxes as other U.S. citizens. They deserve equity. Therefore, hospitals in Puerto Rico should receive the same Medicare reimbursement as all other U.S. hospitals. Puerto Rico hospitals should be phased into a 100 percent federal payment.

Mr. Chairman, I commend you for addressing the great disparity that currently exists in Medicare payments to rural physicians across the United States, including Puerto Rico. In fact, physicians in the Island currently have the lowest geographic cost-of practice index value in the entire country, despite the city of San Juan having the 8th highest cost of living in the United States. As a result, not only are our rural areas suffering, physicians in metropolitan areas such as San Juan are carrying a great burden when they treat Medicare patients. I am pleased that the Committee has included this important provision as part of the legislation discussed today, which will allow for our doctors to be paid appropriately for their great, noble work.

Finally, I would like to thank my colleagues in the House and Senate who have continuously supported us on resolving these critical issues to ensure that Medicare beneficiaries in Puerto Rico are afforded quality healthcare. Thank you, Mr. Chairman, for this opportunity to discuss important healthcare issues for the people of Puerto Rico.

THE PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

Section 1. Short Title; Amendments to Social Security Act; References to BIPA and Secretary; Table of Contents

Current Law

No provision.

Explanation of Provision

The provision specifies the title of the Act and includes a table of contents.

TITLE I - MEDICARE PRESCRIPTION DRUG BENEFIT

SUBTITLE A - MEDICARE VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

Section 101. Medicare Voluntary Prescription Drug Delivery Program

Current Law

In general, Medicare does not cover most outpatient prescription drugs. Despite the general limitation, the law specifically authorizes coverage for the following drugs under specified conditions: drugs used in immunosuppressive therapy (such as cyclosporin) for individuals who have received a Medicare covered organ transplant; erythropoietin (EPO) for the treatment of anemia for persons with chronic renal failure who are on dialysis; drugs taken orally during cancer chemotherapy providing they have the same active ingredients and are used for the same indications as chemotherapy drugs which would be covered if they were not self-administered and were administered as incident to a physician's professional service; hemophilia clotting factors for hemophilia patients competent to use such factors to control bleeding without medical supervision; and drugs that are necessary for the effective use of covered durable medical equipment, including those which must be put directly into the equipment. The program also covers pneumococcal pneumonia vaccines, hepatitis B vaccines, and influenza virus vaccine.

Explanation of Provision

Effective January 1, 2006, a new optional benefit would be established under a new Part

D. Beneficiaries could purchase either "standard coverage" or actuarially equivalent coverage. In 2006, "standard coverage" would have a $275 deductible, 50% cost-sharing for costs between $276 and **[GREATER THAN $3,450]**, then no coverage until the beneficiary had out-of-pocket costs of $3,700; and 10% cost-sharing thereafter. Individuals with incomes below 160% of poverty would receive additional assistance. The bill would rely on private plans to provide coverage and to bear a portion of the financial risk for drug costs. Coverage would be provided through Medicare Prescription Drug Plans or MedicareAdvantage plans.

New Section 1860D - Definitions; Treatment of References to Provisions in MedicareAdvantage Program

Current Law

No provision.

Explanation of Provision

The section would define a number of terms used in the bill. The "Administrator" would be defined as the Administrator of the new Center for Medicare Choices established under the bill.

A "covered drug" would be defined to include drugs, biological products, and insulin which are covered under Medicaid and vaccines licensed under Section 351 of the Public Health Service Act. Coverage would be extended to any use of a covered drug for a medically accepted indication. The term would not include drugs or classes of drugs, or their medical uses, which could be excluded from coverage under Medicaid, except for smoking cessation agents. The term would not include drugs currently covered under Medicare Part A or Medicare Part B to the extent payment is available under those Parts. A drug prescribed for an individual, which would ordinarily be a covered drug, would not be covered if a plan's formulary excluded the drug and the exclusion was not successfully resolved. Further, a Medicare Prescription Drug plan or a MedicareAdvantage plan could exclude drugs which did not meet Medicare's definition of "reasonable and necessary" under Section 1862(a) of the Act or which were not prescribed in accordance with the requirements of the plan or Part D.

An "eligible beneficiary" would be an individual entitled to, or enrolled for, benefits under Part A and enrolled in Part B. An "eligible entity" would be any risk bearing entity that the Administrator determined to be appropriate to provide eligible beneficiaries with benefits under a Medicare Prescription Drug Plan. Eligible entities would include pharmaceutical benefit management companies, wholesale or retail pharmacist delivery systems, insurers (including insurers that offered Medigap policies), other risk bearing entities, or any combination of these. This requirement would not preclude State pharmacy assistance programs from becoming a qualified entity if they meet the requirements.

A "Medicare Prescription Drug Plan" would offer prescription drug coverage under a policy, contract or plan by an eligible entity pursuant to and in accordance with a contract between the Administrator and the entity. The plan would have to be approved by the Administrator.

The provision would specify that Part C requirements relating to MedicareAdvantage would be applied (unless otherwise specified) as if: 1) any reference to a MedicareAdvantage plan included a reference to a Medicare Prescription Drug plan; 2) any reference to a provider-sponsored organization included a reference to an eligible entity, 3) any reference to a contract included a reference to a drug plan contract, and 4) any reference to Part C included a reference to Part D.

Subpart 1 -Establishment of Voluntary Prescription Drug Delivery Program

New Section 1860D-1. Establishment of Voluntary Prescription Drug Delivery Program

Current Law

No provision

Explanation of Provision

The Administrator would provide for and administer a voluntary prescription drug delivery program under which each eligible beneficiary enrolled in Part D would be provided access to drug coverage. All 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.

The program would begin January 2006 and would provide coverage for all therapeutic categories and classes of covered drugs (though not necessarily for all drugs within such categories and classes). Program costs would be paid from the Prescription Drug Account.

New Section 1860D-2. Enrollment Under Program

Current Law

People generally enroll in Part B when they turn 65. Persons who have applied for Social Security or railroad retirement benefits automatically receive a Medicare card when they turn 65. Persons who have not applied for Social Security or railroad retirement benefits must file an application for Medicare benefits. An individual who becomes entitled to Medicare Part A is automatically enrolled in Part B unless he or she specifically refuses this coverage. An aged

person not entitled to Part A may still enroll in Part B.

Persons who delay enrollment in Part B after their initial enrollment period are subject to a premium penalty. Certain persons, including a working individual and/or spouse of a working individual, may be able to delay enrollment in Medicare Part B without being subject to the delayed enrollment penalty.

Explanation of Provision

The Administrator would establish an enrollment process which would be similar to that for Part B. An initial open enrollment period would be established. For beneficiaries eligible as of January 1, 2006, this would be the 7-month period beginning May 1, 2005 and ending November 30, 2005. Persons becoming eligible after this date would have an initial 7-month enrollment period similar to that established for Part B.

Persons enrolling in Part D after their initial enrollment period would be subject to delayed enrollment penalties. The actuarially sound increase for each 12-month period of delayed enrollment would be determined by the Administrator.

Eligible beneficiaries with creditable drug coverage could elect to continue to receive such coverage, not enroll in Part D, and subsequently enroll in Part D without penalty if the plan terminates, ceases to provide, or reduces the value of the prescription drug coverage under the plan to below the actuarial value of standard prescription drug coverage. Subject to certain conditions, creditable drug coverage would include drug coverage through Medicaid, a group health plan, state pharmaceutical assistance program, veterans programs, and Medigap. A special enrollment period would apply for persons losing creditable coverage. In general, it would be the 63-day period beginning on the date the individual lost such coverage. Entitlement would begin the first day of the first month following enrollment.

New Section 1860D-3. Election of a Medicare Prescription Drug Plan

Current Law

The law establishes rules for beneficiary enrollment, disenrollment and termination of enrollment in Medicare+Choice plans.

Explanation of Provision

The Administrator would establish a process through which an eligible beneficiary who was not enrolled in a MedicareAdvantage Plan could enroll in a Medicare Prescription Drug plan serving the geographic area where the beneficiary resides. The beneficiary could make an annual election to change enrollment to another plan. A beneficiary in Part D who fails to enroll in a plan would be enrolled in a plan designated by the Administrator.

The Administrator would use rules similar to the rules established for enrollment, disenrollment and termination of enrollment with MedicareAdvantage plans. Included would be requirements relating to establishment of special election periods and application of the guaranteed issue and renewal provisions. The Administrator would also coordinate enrollments, disenrollments, and terminations of enrollments under Part C with those under Part D.

The enrollment process established by the Administrator would ensure that beneficiaries who enrolled in the first open enrollment period (beginning April 2005) would be permitted to elect an eligible entity prior to January 1, 2006, in order to assure coverage was effective on that date.

Persons enrolled in MedicareAdvantage Plans would receive drug coverage through their MedicareAdvantage Plans and be subject to their enrollment rules.

New Section 1860D-4. Providing Information to Beneficiaries

Current Law

The law requires the Secretary to broadly disseminate information on Medicare+Choice plans to Medicare enrollees in order to promote informed selection of plans.

Explanation of Provision

The bill would require the Administrator to broadly disseminate information to beneficiaries regarding Part D coverage. Current beneficiaries would be provided such information at least 30 days prior to beginning of the first enrollment period.

Information activities would be similar to those performed for MedicareAdvantage and be coordinated with such activities. Comparative plan information would include a comparison of benefits, quality and performance, beneficiary cost-sharing, consumer satisfaction surveys, and other information specified by the Secretary.

New Section 1860D-5. Beneficiary Protections

Current Law

Medicare+Choice plans are required to meet a number of beneficiary protection requirements. They are required to disclose plan information to enrollees. They are required to have procedures relating to coverage decisions, reconsiderations, and appeals. Further, they are required to assure the confidentiality and accuracy of enrollee records.

Marketing material used by Medicare+Choice plans must be approved by the Secretary.

Explanation of Provision

Eligible entities offering Medicare Prescription Drug Plans would be required to disclose plan information comparable to that required for MedicareAdvantage plans. Entities would have to disclose information on access, operation of any formulary, beneficiary cost-sharing, and grievance and appeals procedures. Further, upon request of an individual, they would be required to disclose general information on coverage, utilization, and grievance procedures. An eligible entity would be required to have a mechanism for providing specific information to enrollees, upon request, including information on coverage of specific drugs and changes in its formulary. Entities would be required to provide easily understandable explanation of benefits and a notice of benefits in relation to the initial coverage limit and the annual out-of-pocket limit. The MedicareAdvantage requirements relating to approval of marketing materials would apply to information provided by entities on drug plans.

The bill contains several provisions 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. The procedures would include the issuance of a card or other technology that could be used by a beneficiary to assure access to negotiated prices for which coverage was not otherwise provided under the plan. 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. The Administrator would be required to establish standards to ensure convenient access, including emergency access. The standards would take into account reasonable distances to pharmacy services in both urban and rural areas.

An entity would 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. This additional cost sharing would not count toward the program's cost-sharing requirements or benefit limits.

Plans would be allowed to have formularies. Plans electing to use a formulary would be required to establish a pharmacy and therapeutic committee to develop and review the formulary. The pharmacy and therapeutics committee would include at least one academic expert, at least one practicing physician, and at least one practicing pharmacist, all of whom must have expertise in the care of elderly or disabled persons. The committee would base clinical decisions on the strength of scientific evidence and standards of practice. The committee would establish policies and procedures to educate and inform health care providers concerning the formulary. Drugs could not be removed from the formulary until after appropriate notice had been provided to beneficiaries, physicians, and pharmacists. 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. If a plan offered tiered cost-sharing for covered drugs, an

enrollee would have the right to request that a nonpreferred drug be treated on terms applicable for a preferred drug if the prescribing physician determined that the preferred drug was not as effective for treatment of the same condition for the individual or had adverse effects for the individual.

The 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). For purposes of defining therapeutic categories and classes, the Administrator would be required to use the following compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, the DRUGEX Information System, and American Medical Association Drug Evaluations.

Eligible entities would be required to have a cost-effective drug utilization management program (including incentives to reduce costs when appropriate). They would be required to have a program to control fraud, abuse, and waste. Further, they would be required to have quality assurance measures, including a medication therapy management program, to reduce medical errors and adverse drug interactions. The medication therapy management program would be designed to assure that drugs for beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure) or multiple prescriptions were appropriately used to optimize therapeutic outcomes and reduce the risk of adverse events including adverse drug interactions. The program could include enhanced beneficiary understanding of appropriate use through education, counseling and other appropriate means; increased adherence with prescription regimens through refill reminders, special packaging and other appropriate means; and detection of patterns of overuse and underuse of drugs. The program would be developed in cooperation with pharmacists and physicians. Associated costs would be taken into account by the entity when establishing fees for pharmacists and others providing services under the medication therapy management program.

Pharmacies or other dispensers would be required to assure that beneficiaries are informed at the time of purchase of any difference between the price of the prescribed drug and the lowest cost generic drug that is therapeutically equivalent and bioequivalent and that is available at the pharmacy or other dispenser. Entities would also be required to have meaningful procedures for hearing and resolving grievances, comparable to those established for MedicareAdvantage plans. In addition, eligible entities would be required to meet MedicareAdvantage requirements relating to coverage determinations. Entities would be required to safeguard the privacy of individually identifiable beneficiary information, maintain such records in an accurate and timely manner, ensure timely access by beneficiaries, and otherwise comply with laws relating to patient privacy.

Premiums for a plan would not vary within a region.

New Section 1860D-6. Prescription Drug Benefits

Current Law

No provision

Explanation of Provision

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. 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 **[GREATER THAN $3450]**, then no coverage, except that beneficiaries would have access to negotiated drug prices, until the beneficiary had out-of-pocket costs of $3,700; and 10% cost-sharing thereafter. These amounts would be increased in future years by the percentage increase in average per capita expenditures for covered drugs for the year ending the previous July. 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 standard coverage. Entities could use a variety of cost control mechanisms including formularies, tiered copayments, selective contracting with drug providers, and mail order pharmacies.

A Medicare Prescription Drug Plan or MedicareAdvantage plan could offer a plan design different from standard coverage provided certain conditions were met. The actuarial value of total coverage would have to be at least equal to the actuarial value of standard coverage. The unsubsidized value of coverage would have to be at least equal to the unsubsidized value of standard coverage. Further, the coverage would be designed, based on a representative pattern of utilization, to cover the same percentage of costs up to the initial benefit limit as provided under the standard plan. The limitation on out-of-pocket expenditures would be the same as under standard coverage. The entity would have to apply for and receive approval from the Administrator for an alternative benefit design.

Qualified drug plans would be required to provide beneficiaries with access to negotiated prices (including all discounts, direct or indirect subsidies, rebates, other price concessions, or direct or indirect remunerations), regardless of the fact that no benefits may be payable. The entity would be required to issue a card or other technology for this purpose. The Administrator would be required to provide for development of national standards relating to a standardized format for the card or other technology. The standards would be compatible with those provided for under the administrative simplification and electronic prescribing requirements of Title XI. The standards would be implemented no later than January 1, 2008.

The bill would exempt any prices negotiated by a Medicare Prescription Drug plan, MedicareAdvantage plan, or qualified retiree program from Medicaid's determination of "best price" for purposes of the Medicaid drug rebate program.

New Section 1860D-7. Requirements for Entities Offering Medicare Prescription Drug Plans; Establishment of Standards

Current Law

No provision.

Explanation of Provision

In general, an entity eligible to offer a Medicare Prescription Drug Plan would be organized and licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each state it offers a plan. Alternatively, the Administrator could waive the requirement that the entity be licensed in the state, if the Administrator determined that grounds for approval of the application had been met. By January 1, 2005, the Administrator would, in consultation with the National Association of Insurance Commissioners, establish and publish solvency standards for non-licensed entities.

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. Entities would be permitted to obtain private reinsurance for the portion of the costs for which they were at risk.

Beneficiaries could not elect a Medicare Prescription Drug Plan unless the Administrator had entered into a contract with the eligible entity for the plan. A contract with an entity could cover more than one plan.

By January 1, 2005, the Administrator would be required to establish by regulation standards to implement Part D. Such standards would be periodically reviewed and revised as appropriate. Significant new regulatory requirements could only be implemented at the beginning of a calendar year. The standards would supersede any state law and regulation to the extent such law or regulation was inconsistent with such standards and in the same manner those standards were superseded for MedicareAdvantage plans. Standards specifically superseded include those relating to benefits, requirements relating to inclusion or treatment of providers, coverage determinations (including related grievance and appeals processes), and requirements relating to marketing materials and summaries and schedules of benefits for a plan.

States would be prohibited from imposing a premium or similar tax with respect to premiums paid to the Administrator for Medicare Prescription Drug Plans and any payments

made by the Administrator to eligible entities offering such a plan.

Subpart 2 - Prescription Drug Delivery System

New Section 1860D-10. Establishment of Service Areas

Current Law

No provision.

Explanation of Provision

The Administrator would be required to establish by April 15, 2005, and periodically review, service areas in which plans could offer benefits. The Administrator would establish service areas so that they maximized the availability of Medicare Prescription Drug Plans to eligible beneficiaries and minimized the ability of entities offering plans to favorably select beneficiaries. In establishing the service areas, the Administrator shall establish at least 10 service areas which must include at least one state. The Administrator may not divide states so that portions of a state are in different service areas. To the extent possible, the Administrator shall include multi-state metropolitan statistical areas (MSAs) in a single service area. The Secretary may divide MSAs where it is necessary to establish service areas of such size and geography as to maximize plan participation.

New Section 1860D-11. Publication of Risk Adjusters

Current Law

No provision.

Explanation of Provision

The Administrator would be required to establish an appropriate method for adjusting payments to plans to take into account, in a budget neutral manner, variations in costs based on the differences in actuarial risk of different enrollees being served. The Administrator would be required to publish such risk adjusters not later than April 15 each year, beginning in 2005.

New Section 1860D-12. Submission of Bids for Proposed Medicare Prescription Drug Plans

Current Law

No provision.

Explanation of Provision

Entities would submit bids containing information on proposed plans including benefits, actuarial value of the qualified prescription drug coverage, the service area for the plan, and the monthly premium. Premium information would have to include an actuarial certification of the basis for the premium, the portion of the premium attributable to benefits in excess of standard coverage, and the reduction in bids attributable to reinsurance payments. Entities would also be required to provide information on whether the entity planned to use any funds in the plan stabilization reserve fund that were available to the entity for the purpose of stabilizing or reducing the monthly premium.

Service areas could either be the entire area of one of the service areas established by the Administrator or the entire area covered by Medicare. Entities could submit separate bids for multiple service areas, provided each bid was for a single service area.

New Section 1860D-13. Approval of Proposed Prescription Drug Plans

Current Law

No provision.

Explanation of Provision

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 and any stabilization funds used. The Administrator is required to apply the Federal Employees Health Benefits Program (FEHBP) standard, stipulating that each bid submitted by an entity for a qualified plan must reasonably and equitably reflect the cost of benefits provided under that plan. 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 disapprove, or limit enrollment in, a proposed plan based on costs to beneficiaries, the quality of coverage and benefits, the adequacy of the plan network, and other factors determined appropriate by the Administrator. 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 shall approve at least 2 contracts to offer a Medicare Prescription Drug plan in an area. Contracts would be

awarded for 2 years.

If at least 2 plans do not meet the minimum requirements for accepting risk, the Administrator shall reduce the amount of risk required by plans in a region. This would be achieved by reducing the percentages applicable to the first and second risk corridors established under the bill. Alternatively, the reinsurance percentage could be increased. The Administrator could not provide for the full underwriting of financial risk for any entity and could not provide for the underwriting of any financial risk for a public entity. The Administrator would seek to maximize the assumption of financial risk to ensure fair competition among plans.

Not later than September 1 of each year, beginning in 2005, the Administrator shall make a determination as to whether there are 2 approved bids. If not, 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 1 contract for each such area. A single entity could be awarded contracts for more than one such area. Premiums would be set at the premium amount that would apply if the plan premium equaled the national weighted average premium, as adjusted for differences in drug utilization. The contract with the plan would provide for payments to the plans for the negotiated costs of covered drugs and payment of prescription management fees tied to performance management fees established by the Administrator. Performance requirements established by the Administrator would include the following; 1) the entity contained costs to the Prescription Drug Account and to beneficiaries; 2) the entity provided quality clinical care; and 3) the entity provided quality services.

The fallback plan would not be permitted to engage in any marketing or branding. In selecting a default enrollment plan, the Administrator shall not select the fallback plan if another contract has been awarded. Entities that have submitted bids to be a qualified risk-bearing entity may not submit a bid to be a fallback plan.

New Section 1860D-14. Computation of Monthly Standard Coverage Premiums

Current Law

No provision.

Explanation of Provision

The Administrator would be required to compute a monthly standard coverage premium for each Medicare Prescription Drug plan and for each MedicareAdvantage plan. This would

equal the value of standard coverage or actuarially equivalent coverage if the plan provided no additional benefits. If the plan offered additional benefits, the calculation would reflect only the value of standard coverage or, alternatively the approved plan premium for the required qualified coverage plan offered by the entity.

New Section 1860D-15. Computation of Monthly National Average Premium

Current Law

No provision.

Explanation of Provision

Each year, beginning in 2006, the Administrator would be required to compute a monthly national average premium equal to the average of the monthly standard coverage premium for each Medicare Prescription Drug plan and each MedicareAdvantage plan. The calculation would be a weighted average based on the number of enrollees in the plan in the previous year. The Administrator would establish procedures for making such calculation for 2005.

New Section 1860D-16. Payments to Eligible Entities

Current Law

Medicare makes per capita monthly payments to Medicare+Choice organizations.

Explanation of Provision

The Administrator would pay each entity offering a Medicare Prescription Drug Plan an amount equal to the full monthly approved premium, with appropriate risk adjusters. Payment terms would be determined by the Administrator and be based on terms used for MedicareAdvantage plans. Payments to plans would be geographically adjusted in a budget-neutral manner to account for differences in prescription drug prices across service areas.

A portion of total payments to plans would be subject to risk. Entities would be required to notify the Administrator for each year (beginning in 2007) of the total actual costs the entity incurred in providing standard coverage in the preceding year and a breakdown for each drug paid for by the plan and the negotiated price for each such drug. The notification would not include spending for administrative costs, amounts spent for coverage in excess of standard coverage, or amounts for which the entity subsequently received reinsurance payments.

The provision would establish risk corridors which would be defined as specified percentages above and below a target amount. The target amount would be defined as the total of

plan premiums minus a percentage (negotiated between the Administrator and the entity) for administrative costs. No payment adjustment would be made if allowable costs were not more than the first threshold upper limit or less than the first threshold lower limit for the year, i.e. if the plans were within the first risk corridor. A portion of any plan spending above or below these levels would be subject to risk adjustments. If allowable costs exceeded the first threshold upper limit, then payments would be increased. If allowable costs were below the first threshold lower limit, payments would be reduced.

During 2006 and 2007, plans would be at full risk for drug spending within 2.5% above or below the target. Plans would be at risk for 25% of spending exceeding 2.5% (first threshold upper limit) and below 5.0% of the target (second threshold upper limit). That is their payments would equal 75% of the allowable costs for spending in this range. They would be at risk for 10% of the spending exceeding 5% of the target. That is their payments would equal 90% of the allowable costs for spending in this range. Conversely, if plans fell below the target, they would share the savings with the government. They would have to refund 75% of the savings if costs fell between 2.5% and 5% below the target level, and 10% of any amounts below 5% of the target.

A special transition corridor would be established in the first two years. The Administrator would make a payment adjustment if the Administrator determined that 60% or more of all participating plans (including MedicareAdvantage plans) representing at least 60% of covered beneficiaries had allowable costs that were more than 2.5% above the target. Risk corridor payments would equal 90% of any spending greater than 2.5% of the target but below 5% of the target.

For 2007-2011, the risk corridors would be modified. Plans would be at full risk for drug spending within 5.0% above or below the target level. Plans would be at risk for 50% of spending exceeding 5.0% and below 10.0% of the target level. They would be at risk for 10% of the spending exceeding 10% of the target level. Payments would be increased by 50% of allowable costs exceeding the first threshold upper limit and 10% for costs exceeding the second threshold upper limit. Conversely, if plans fell below the target, they would share the savings with the government. They would have to refund 50% of the savings if costs fell between 5% and 10% below the target level, and 10% of any amounts below 10% of the target. For years after 2011, the Administrator would establish risk corridors. The first threshold risk percentage could not be less than 5% and the second threshold risk percentage could not be less than 10%.

Administrative costs would be not be included in the calculation of whether or nor plan spending fell within a particular risk corridor. Administrative costs would be negotiated separately, on a plan by plan basis, with the Administrator. Administrative costs would be subject to performance risk.

For purposes of making risk corridor calculations, allowable costs would be based on actual costs reported by the plan. The Administrator would adjust this amount in cases where

actual costs for a covered drug exceeded the average negotiated price for such drug in the year.

The Administrator could require disclosure of any data as needed to administer the benefit. The Administrator would have the right to inspect and audit any books and records of the entity pertaining to amounts reported for drug spending. Information could be used by officers and employees of the Department of Health and Human Services, but only to the extent necessary to carry out this section.

The Administrator would be required to establish a stabilization reserve fund, within the Prescription Drug Account. Amounts in this fund would be made available to eligible entities beginning with their 2008 contract year. Payments to the fund would be determined as follows: If the target amount for a plan for any year 2006 - 2010 exceeded applicable costs by more than 3% for the year, the Administrator would reduce payments to the plan by such excess and deposit such amount in the fund on behalf of the entity. Applicable costs would be defined as the sum of allowable costs and the amount by which monthly payments were reduced through application of the risk corridor provisions. At appropriate intervals, the Administrator would notify a participating entity of the balances in any of its stabilization accounts. Beginning in 2008, entities would be permitted to use account funds to stabilize or reduce plan premiums. The accounts would expire after 5 years. Any amounts not used by an eligible entity or that was deposited for use by an entity that no longer had a Part D contract would revert to the use of the Prescription Drug Account.

New Section 1860D-17. Computation of Beneficiary Obligation

Current Law

No provision.

Explanation of Provision

If the plan's monthly approved premium for standard coverage was equal to the national monthly weighted average premium for such coverage, the beneficiary would pay: 1) 25/70 expressed as a percentage of the monthly national average. If the plan's monthly approved premium was less than the national average the beneficiary would pay: 1) 25/70 expressed as a percentage of the monthly national average, *minus*, 2) the difference between the national average and the plan's premium. If the plan's monthly premium was greater than the national average, the beneficiary would pay: 1) 25/70 expressed as a percentage of the monthly national average, *plus* 2) the difference between the national average and the plan's premium.

New Section 1860D-18. Collection of Beneficiary Obligation

Current Law

Beneficiaries pay a monthly Part B premium. In general, this is collected through a withholding from social security checks.

Explanation of Provision

Premiums would be collected in the same manner as Part B premiums. The collections would be credited to the Prescription Drug Account. The Administrator would transmit the information necessary for collection to the Commissioner of Social Security.

New Section 1860D-19. Premium and Cost-Sharing Subsidies for Low-Income Individuals

Current Law

Some low-income aged and disabled Medicare beneficiaries are also eligible for full or partial coverage under Medicaid. Medicaid is a federal-state program which provides health insurance coverage to certain low-income individuals. Within broad federal guidelines, each state sets its own eligibility criteria, including income eligibility standards. Persons meeting the state standards are entitled to *full* coverage under Medicaid. Persons entitled to *full* Medicaid protection generally have all of their health care expenses met by a combination of Medicare and Medicaid. For these "dual eligibles," Medicare pays first for services both programs cover. Medicaid picks up Medicare cost-sharing charges and provides protection against the costs of services generally not covered by Medicare. Perhaps the most important service for the majority of dual eligibles is prescription drugs. These dual eligibles typically have comprehensive drug coverage with only nominal cost-sharing.

Federal law specifies several population groups that are entitled to more *limited* Medicaid protection. These are qualified Medicare beneficiaries (QMBs), specified low income beneficiaries (SLMBs), and certain qualified individuals. QMBs and SLMBs are not entitled to Medicaid's prescription drug benefit unless they are also entitled to full Medicaid coverage under their state's Medicaid program. Qualifying individuals are *never* entitled to Medicaid drug coverage (because, by definition, they are not eligible for full Medicaid benefits).

Qualified Medicare Beneficiaries (QMBs) are aged or disabled persons with incomes at or below the federal poverty level. In 2003, the monthly level is $769 for an individual and $1,030 for a couple. ($9,228 per year for an individual and $12,360 per year for a couple). (The qualifying levels are higher than the HHS federal poverty guidelines because, by law, $20 per month of unearned income, rounded to the next dollar, is disregarded in the calculation.) QMBs must also have assets below $4,000 for an individual and $6,000 for a couple. QMBs are entitled to have their Medicare cost-sharing charges, including the Part B premium, paid by the federal-state Medicaid program. Medicaid protection is limited to payment of Medicare cost-sharing charges (i.e., the Medicare beneficiary is *not* entitled to coverage of Medicaid plan services unless the individual is otherwise entitled to Medicaid.)

Specified Low-Income Medicare Beneficiaries (SLMBs) are persons who meet the QMB criteria, except that their income is over the QMB limit. The SLMB limit is 120% of the federal poverty level. In 2003, the monthly income limits are $918 for an individual and $1,232 for a couple ($11,016 per year for an individual and $14,784 for a couple). Medicaid protection is limited to payment of the Medicare Part B premium (i.e., the Medicare beneficiary is *not* entitled to coverage of Medicaid plan services unless the individual is otherwise entitled to Medicaid.)

Qualifying Individuals (QI-1s) are persons who meet the QMB criteria, except that their income is between 120% and 135% of poverty. The monthly income limit for QI-1 for an individual is $1,031 and for a couple $1,384 ($12,372 per year for an individual and $16,608 for a couple). Medicaid protection for these persons is limited to payment of the monthly Medicare Part B premium. In general, Medicaid payments are shared between the federal government and the states according to a matching formula. However, expenditures under the QI-1 program are paid 100% by the federal government (from the Part B trust fund) up to the state's allocation level. A state is only required to cover the number of persons which would bring its spending on these population groups in a year up to its allocation level. This temporary program, originally slated to end September 30, 2002, has been extended through September 30, 2003, by P.L.108-7.

Eligibility determinations for Medicaid, QMB, SLMB, and QI-1 programs are made by the states.

Explanation of Provision

Medicaid beneficiaries eligible for medical and drug benefits under their state Medicaid program would continue to receive drug benefits through Medicaid. Persons meeting the definition of QMB, SLMB, or QI-1, and not eligible for Medicaid medical and 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 the Part D 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. Plans could waive or reduce cost-sharing otherwise applicable.

Persons with incomes below 160% of poverty, not otherwise eligible for low-income 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, and10.0% cost-sharing for costs above the catastrophic limit. Plans could waive or reduce cost-sharing otherwise applicable.

QMBs, SLMBs and QI-1s and other Part D enrollees with incomes below 160% of poverty could enroll in MedicareAdvantage and receive their low-income assistance through such plans.

Beginning May 1, 2005, the Social Security Administration shall determine eligibility for low-income benefits, including for dual eligibles, QMBs, SLMBs, QI1s, and those below 160% FPL. Eligibility determinations would be made through offices of the Social Security Administration. This provision would amend a BIPA requirement that the Commissioner of Social Security shall identify and notify individuals entitled to benefits under the Medicare savings programs to include individuals eligible for low income assistance under Part D of Medicare. In addition, States could make low-income eligibility determinations through their state Medicaid programs. The Administrator would implement a process to notify the eligible entity or MedicareAdvantage plan that the individual is eligible for a cost-sharing subsidy and the amount of the subsidy. The entity would reduce the applicable cost-sharing and submit information to the Administrator on the amount of the reduction. The Administrator would periodically and on a timely basis reimburse the entity or organization for the amount of the reductions.

By January 1, 2005, the Secretary shall submit a report to Congress to recommend a voluntary option for dual eligibles to enroll in Part D drug plans.

Section 1860D-20. Reinsurance Payments for Expenses Incurred in Providing Prescription Drug Coverage Above the Annual Out-of-Pocket Threshold

Current Law

No provision

Explanation of Provision

The provision would provide for reinsurance payments. These payments would be made to plans in the case of individuals whose spending exceeded the out-of-pocket limit. Payments to plans would equal 80% of allowable drug costs exceeding the limit. Allowable costs would be equal to actual costs above the limit, subject to an adjustment. The Administrator would reduce actual costs to the extent such amount was based on costs for specific covered drugs that were

greater than the average cost for the covered drug for the year (as determined under new Section 1860D-16). Entities would be required to notify the Administrator of the total actual costs (if any) incurred for providing benefits for an individual after the individual exceeded the out-of-pocket threshold. The entity would be required to provide a breakdown for each drug paid by the plan over the limit and the negotiated price for each such drug. Administrative costs and costs for coverage in excess of the standard benefit would not be included.

Payment methods would be determined by the Administrator. Such methods could include the use of interim payments. Reinsurance payments could be made to qualifying entities, MedicareAdvantage plans and sponsors of qualified retiree prescription drug plan. Sponsors of qualified retiree prescription drug plans would have to attest that coverage under the retiree plan met or exceeded the requirements for qualified drug coverage.

New Section 1860D-21. Direct Subsidy for Sponsor of a Qualified Retiree Prescription Drug Plan for Enrollees Eligible for, But Not Enrolled in this Part

Current Law

No provision.

Explanation of Provision

The Administrator would make direct payments to sponsors of qualified retiree prescription drug plans (as defined under New Section 1860D-20) for each beneficiary enrolled in the plan who was not enrolled in Part D. The amount of the payment would equal **45/70** expressed as a percentage of the monthly national average premium for the year, as adjusted by risk adjusters. The Administrator would establish payment methods which could include interim payments. Payments would be made from the Prescription Drug Account.

Subpart 3 -Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund

New Section 1860D-25. Establishment

Current Law

Medicare Part B is financed by a combination of enrollee premiums and federal general revenues. Income from these sources is credited to the Federal Supplementary Insurance Trust fund. Payments are made from the Trust Fund for Part B benefits.

Explanation of Provision

A separate account, known as the Prescription Drug Account, would be established within the Part B Trust Fund. Funds in this Account would be kept separate from other funds within the Trust Fund. Payments would be made from the Account to eligible entities and MedicareAdvantage plans and for low-income subsidies, reinsurance payments, and administrative expenses. Appropriations would be made to the Account equal to the amount of payments and transfers made from the Account.

Effective Date

Enactment.

Section 102. Study and Report on Permitting Part B Only Individuals to Enroll in Medicare Voluntary Prescription Drug Delivery Program.

Current Law

No provision.

Explanation of Provision

The provision would require the Administrator to conduct a study, and report to Congress by January 1, 2005, on allowing persons not entitled to Part A, but enrolled in Part B, to enroll in Part D.

Effective Date

Enactment.

Section 103. Rules Relating to Medigap Policies That Provide Prescription Drug Coverage

Current Law

Beneficiaries may purchase individual health insurance polices to supplement their Medicare benefits. These policies are referred to as Medigap policies. Individuals who first purchase a Medigap policy on or after July 30, 1992, select from one of 10 standardized plans though not all 10 plans are offered in all states. The 10 plans are known as Plans A through J. Plan A covers a basic package of benefits. Each of the other nine plans includes the basic benefits plus a different combination of additional benefits. Plan J is the most comprehensive. Plans H, I, and J offer some drug coverage.

Explanation of Provision

Effective January 1, 2006, Medigap drug policies could not be sold to Part D enrollees.

Persons who had such policies could obtain Medigap coverage without drug benefits. Beneficiaries who sought to enroll during the Part D open enrollment period established for current beneficiaries would be guaranteed issuance of such non-drug policies (without an exclusion based on preexisting conditions).

Effective Date

Enactment.

Section 104. Medicaid Amendments

Current Law

States make eligibility determinations for their Medicaid populations as well as for the QMB/SLMB/QI-1 populations. Federal matching payments generally equal 50% of administrative costs.

Qualifying Individuals (QI-1s) are persons who meet the QMB criteria, except that their income is between 120% and 135% of poverty. Eexpenditures under the QI-1 program are paid 100% by the federal government (from the Part B trust fund) up to the state's allocation level. A state is only required to cover the number of persons which would bring its spending on these population groups in a year up to its allocation level. This temporary program, originally slated to end September 30, 2002, has been extended through September 30, 2003, by P.L.108-7.

Current Medicaid law requires manufacturers to pay state Medicaid programs a basic rebate for single source and innovator multiple source drugs. Basic rebates are calculated by comparing the average manufacturer price for a drug (the average price paid by wholesalers) to the "best price," which is the lowest price offered by the manufacturer in the same period to any wholesaler, retailer, nonprofit, or public agency. For purposes of determining Medicaid rebates, prices paid by a number of Federal and state entities are excluded from the definition of "best price."

Explanation of Provision

The provision would require states to make low-income eligibility determinations for low income subsidies. States would be required, for purposes of the transitional prescription drug card assistance program, to establish eligibility standards consistent with that program; establish procedures for providing presumptive eligibility determinations (similar to that which currently apply for low-income pregnant women and children); conduct eligibility determinations for the card program; and communicate to the Secretary information on eligibility determinations or discontinuations. For purposes of the low-income subsidies for the new Part D program, states would be required to make eligibility determinations; inform the Administrator of cases where

eligibility was established, and otherwise provide the Administrator with any information required to carry out Part D.

The federal government would pay an enhanced matching rate for administrative costs associated with making eligibility determinations for low-income subsidies. The rate would be 75% for the period January 1, 2004 - September 30, 2005, 70% for fiscal year 2006, 65% for FY 2007, and 60% beginning in FY 2008.

In addition, states would be entitled to enhanced matching for the costs associated with designing, developing, acquiring and installing improved eligibility determination systems, including hardware and software, for low-income subsidy programs. The enhanced rate would be 90% for fiscal years 2004, 2005, and 2006. The systems would be required to comply with any standards established by the Secretary for improved eligibility systems. Further, the systems would have to be compatible with the standards established under the administrative simplification provisions of Title XI of the Social Security Act.

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. The minimum standards are defined as follows. A state would be required to meet all current law coverage standards for dual eligibles under Medicaid, including nominal cost-sharing requirements. States could not place a limit on the number of prescriptions. Further, States would be required to meet Part D standards relating to the definition of therapeutic categories, definition of covered drugs, the requirement for coverage of drugs in each therapeutic class, and minimum standards for geographic access.

Residents of the territories would not be eligible for low-income subsidies. Instead, territories that chose to provide assistance to their low-income residents would receive an increase in amounts otherwise paid to the territory under Medicaid. The aggregate amount available would be $20 million for the period January 1, 2006 - September 30, 2006. In subsequent fiscal years, the aggregate amount would be the amount available the previous year, increased by the percentage increase used to make the annual update to the cost-sharing amounts under Part D.

The provision would extend the QI-1 program through December 2008 with total annual allocations of $400 million through fiscal year 2008 and $100 million for the first quarter of fiscal 2009.

The provision would exempt negotiated prices by any qualified plan offering Medicare drug coverage from the calculation of Medicaid "best price."

Effective Date

Enactment.

Section 105. Expansion of Membership and Duties of Medicare Payment Advisory Commission (MedPAC)

Current Law

MedPAC is an independent federal body, established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program.

Explanation of Provision

The provision would expand the membership to 19 and specify that the membership would include experts in the area of pharmacology and prescription drug benefit programs. MedPAC duties would be expanded to include review of competition among eligible entities offering Medicare Prescription Drug plans and beneficiary access to such plans and covered drugs, particularly in rural areas.

Effective Date

Enactment.

Subtitle B- Medicare Prescription Drug Discount Card With Benefit Dollars for Low-Income Beneficiaries

Section 111. Medicare Prescription Drug Discount Card with Benefit Dollars for Low-Income Beneficiaries

New Section 1807. Medicare Prescription Drug Discount Card Endorsement Program

Current Law

No provision.

Explanation of Provision

The provision would add a new Section 1807 to the Social Security Act, *Medicare Prescription Drug Discount Card Endorsement Program*. The Secretary would establish a program under which the Secretary would endorse card programs offered by prescription drug

card sponsors meeting certain requirements and would make available information on such programs to beneficiaries. Eligible sponsors would be entities with demonstrated experience and expertise in operating a prescription drug discount card program or similar program that the Secretary determined to be appropriate to provide benefits to Medicare beneficiaries. Such entities would include pharmaceutical benefit management companies, wholesale or retail pharmacist delivery systems, insurers, other entities, or any combination of these.

Any individual entitled to, or enrolled in, Part A and enrolled in Part B would be eligible to enroll in an endorsed prescription drug card program. The Secretary would be required to establish procedures for identifying eligible beneficiaries. The Secretary would also be required to establish procedures under which beneficiaries could make an election to enroll and disenroll in an endorsed card program. A beneficiary could only be enrolled in one endorsed program at a time. Card sponsors could charge annual enrollment fees, not to exceed $25. The fee would be the same for all eligible Medicare beneficiaries enrolled in the program and would be collected by the card sponsor.

The Secretary would provide information which compared the costs and benefits of various programs. This information dissemination, intended to promote informed choice, would be coordinated with the dissemination of other educational information on other Medicare options. Each card sponsor would make available to each beneficiary (through the Internet or otherwise) information that the Secretary identified as being necessary to provide for informed choice by beneficiaries among endorsed programs; this would include information on enrollment fees, negotiated prices, and services related to drugs offered under the program. The sponsor would have to provide information on how the formulary functioned. The Medicare toll-free number, 1-800-MEDICARE, would be used to receive and respond to inquiries and complaints.

Each endorsed drug card program would have to meet beneficiary protection requirements, including those relating to beneficiary appeals and marketing practices. They would also have to ensure that beneficiaries were not charged more than the lower of the negotiated retail price or the usual and customary price. Each card sponsor would secure the participation of a sufficient number of pharmacies that distributed drugs directly to patients to ensure convenient access for beneficiaries enrolled in the program. The Secretary would determine whether convenient access was provided; mail order pharmacies would not be included in the determination. Each card sponsor would be required to have in place procedures for assuring that quality service was provided to eligible beneficiaries enrolled in a prescription drug discount card program. They would also have to safeguard individually identifiable information in accordance with the Health Insurance Portability and Accountability Act (HIPAA). Sponsors would be prohibited from charging any fees, except for the annual enrollment fee. Card sponsors could not recommend switching an eligible beneficiary to a drug with a higher negotiated price, unless a licensed health professional recommended a switch based on a clinical indication. Negotiated prices could not change more than once every 60 days.

Card sponsors would provide enrolled beneficiaries with access to negotiated prices used

by the sponsor for payment for prescription drugs, provided such drugs were not excluded under the program's formulary. The term negotiated price would include all discounts, direct or indirect subsidies, rebates, price concessions, and direct or indirect remunerations. Medicaid negotiation rules, including rebate requirements, would not apply.

Each card program would be required to provide pharmaceutical support services such as education, counseling, and services to prevent adverse drug interactions. Each card sponsor would issue a discount card to program enrollees.

Sponsors seeking endorsement of a card program would submit required information to the Secretary. The Secretary would review the information and determine whether to endorse the program. A program could not be approved unless it and the sponsor complied with the requirements of the new Section 1807.

Sponsors could use a formulary. Sponsors electing to use a formulary would be required to establish a pharmaceutical and therapeutic committee (that included at least one academic expert, at least one practicing physician and at least one practicing pharmacist) to develop and review the formulary. The committee would base clinical decisions on the strength of scientific evidence and standards of practice. The formulary would have to include drugs within each therapeutic category and class of covered drugs (as defined by the Secretary) although not necessarily for all drugs within such categories and classes The committee would establish policies and procedures to educate and inform health care providers concerning the formulary. Drugs could not be removed from the formulary until after appropriate notice had been provided to beneficiaries, physicians, and pharmacies. The Secretary would provide appropriate oversight to ensure compliance of programs; including verification of the negotiated prices and services provided. Each program sponsor would be required to report to the Secretary on program performance, use of drugs by beneficiaries, financial information of the sponsor, and other information required by the Secretary. The Secretary could not disclose any proprietary data that was reported. The Secretary could use Parts A and B claims data for purposes of conducting a drug utilization review program.

Section 1807A. Transitional Prescription Drug Assistance Card Program for Eligible Low-Income Beneficiaries

Current Law

No provision.

Explanation of Provision

The provision would add a new Section 1807A to the Social Security Act, *Transitional Prescription Drug Assistance Card Program for Eligible Low-Income Beneficiaries.* The Secretary would award contracts to prescription drug card sponsors, offering a program that was

endorsed by the Secretary under the new Section 1807, to offer a prescription drug card assistance program to eligible low-income beneficiaries. The program would begin no later than January 1, 2004. The Secretary would provide for a transition and discontinuation of the drug card program and the low-income assistance card program when the new Part D program became effective. The transitional programs would continue to operate at least 6 months after the date benefits first became available under Part D.

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, effective January 1, 2004. These persons would have access, through a drug discount card, to up to $150 per calendar quarter. Beneficiaries would be subject to cost-sharing requirements which could not be less than 10% of the negotiated price for a drug. Cost-sharing charges would not count against the $150 available per calendar quarter. The Secretary would establish procedures whereby spouses, both of whom were enrolled in drug assistance card programs, could use the benefits on the other spouse's card. At a minimum, card sponsors would provide low-income enrollees with a minimum of a 20% discount from the average wholesale price for each covered drug.

The Secretary would establish procedures under which beneficiaries would make annual elections to enroll or disenroll in a drug card assistance program. An eligible low-income beneficiary could enroll in only 1 program and could not change the election after enrollment (except when a program ceased operation or under other unusual circumstances). Each sponsor offering an assistance card program would be required to enroll any low-income person wishing to enroll if the program served the geographic area where the beneficiary resides. An individual enrolling in an assistance card program would be simultaneously enrolled in a discount card program offered by the sponsor. Enrollment fees would be waived for these individuals and would instead be paid by the Secretary.

Eligible beneficiaries would have to be provided the information required for the discount card program. In addition, sponsors would be required to notify low-income enrollees, on a periodic basis, of the amount of coverage remaining and on the grievance and appeals process under the program.

Each card sponsor would secure the participation of a sufficient number of pharmacies that distributed drugs directly to patients to ensure convenient access for beneficiaries enrolled in the program. The Secretary would determine whether convenient access was provided; mail order pharmacies would not be included in the determination. Further, appropriate arrangements would have to be made for persons residing in long-term care facilities.

The Secretary would be required to establish procedures under which benefits under the assistance card program were coordinated with other coverage the beneficiary had such as that under a state pharmaceutical assistance program, group health insurance, Medicare+Choice plan, or Medigap.

Drug discount card managers could establish formularies. A low-income 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 the individual or had adverse effects for the individual. If a plan offered tiered cost-sharing for covered drugs, an enrollee would have the right to request that a nonpreferred drug be treated on terms applicable for a preferred drug if the prescribing physician determined that the preferred drug was not as effective for the individual or had adverse effects for the individual.

Sponsors offering assistance card programs would be required to process claims, negotiate with brand name and generic manufacturers and others for low prices, track individual beneficiary expenditures, and perform other functions specified by the Secretary. Each sponsor would receive data exchanges in a format specified by the Secretary.

Entities would be required to assure that low-income beneficiaries were informed at the time of purchase of any difference between the price of the prescribed drug and the lowest cost generic drug that was therapeutically equivalent and bioequivalent and that was available at the pharmacy or other dispenser. Entities would also be required to have meaningful procedures for hearing and resolving grievances, comparable to those established for Medicare+Choice plans. In addition, eligible entities would be required to meet Medicare+Choice requirements relating to coverage determinations.

Sponsors seeking to offer an assistance program would be required to submit information to the Secretary, in the manner specified by the Secretary. The Secretary could not approve a program unless the sponsor and program met the requirements of the new Section 1807A. Further, the Secretary would have to determine that the entity was appropriate to provide benefits to low-income beneficiaries, was able to manage the monetary assistance provided under the program, agreed to submit to audits by the Secretary, and provided other assurances require by the Secretary. There would be no limit on the number of sponsors who could be awarded contracts. The contract would be for the lifetime of the program and cover the same service area served by the sponsor under the card program under Section 1807. The sponsor could submit an application for endorsement under both programs simultaneously.

The Secretary would pay sponsors the amount agreed to in the contract between the two. Payments would be made from the Part B trust fund but would not be considered in the calculation of the Part B premium.

Effective Date

Enactment.

Indexing Part B Deductible to Inflation

Current Law

Under Part B, Medicare generally pays 80 percent of the approved amount for covered services after the beneficiary pays an annual deductible of $100. The Part B deductible has set at $100 since 1991.

Explanation of Provision

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. The amount would be rounded to the nearest dollar.

Effective Date

Upon enactment.

SUBTITLE C — STANDARDS FOR ELECTRONIC PRESCRIBING

Section 111. Standards for Electronic Prescribing

Current Law. Part C (Administrative Simplification) in Title XI of the Social Security Act requires the Secretary to develop transaction and security standards to support the growth of electronic record keeping and claims processing in the nation's health care system.

Section 1171 defines health care clearinghouse, health care provider, health plan, personally identifiable health information, and standard setting organization. Section 1172 specifies that the administrative simplification standards apply to individual and group health plans, health care clearinghouses, and health care providers who transmit health information electronically in a standard format in connection with one of the transactions specified in Section 1173, or who rely on third-party billing services to conduct such transactions. The Secretary is required either to adopt standards that have already been developed by standard setting organizations or to develop different standards, provided they substantially reduce administrative costs to health plans and providers. If no standard has been adopted by a standard setting organization, the Secretary must develop a new standard based on the recommendations of various specified organizations and agencies.

Section 1173 instructs the Secretary to adopt the following standards: (1) uniform electronic formats for various common transactions between health care providers and health plans (e.g., health claims, eligibility and enrollment); (2) code sets for data elements in standard electronic transactions; (3) unique health identifiers for individuals, employers, plans, and providers; (4) security standards to safeguard confidential patient information against unauthorized access, use, or disclosure; and

(5) electronic signatures to verify the authenticity of transactions. Section 1174 provides a timetable for the adoption of the administrative simplification standards and permits the Secretary to modify the standards as frequently as once every 12 months.

Section 1175 requires health plans and providers that process electronic transactions to use standard formats and data elements. Plans and providers may transmit and receive such data either directly or by contracting with a clearinghouse to convert nonstandard data elements into standard transactions. Most entities covered by the administrative simplification standards have 24 months to comply. Small health plans have 36 months to comply.

Section 1176 establishes civil monetary penalties of up to $25,000 per person for violations of the standards. Section 1177 establishes criminal penalties for wrongfully obtaining or disclosing personally identifiable health information. Penalties range from a $50,000 fine and/or 1 year in prison, up to a $250,000 fine and/or up to 10 years in prison if the offense is committed with the intent to sell, transfer, or use the information for commercial advantage, personal gain, or to inflict malicious harm. Section 1178 specifies that the standards preempt contrary provisions in state law pertaining to health information. However, the standards may not preempt or limit state laws that are necessary to prevent fraud and abuse, regulate health insurance companies, or report on health care delivery and costs. Also, the standards may not limit the authority of the state to collect and report public health statistics.

Explanation of Provision. The provision would establish a new Part D in Title XI of the Social Security Act mandating the development or adoption of standards for transactions and data elemetns for such transactions, to enable the electronic transmission of medication history, eligibility, benefit and other prescription information. In developing the standards, the Secretary is required to consult with representatives of physicians, hospitals, pharmacists, standard setting organizations, pharmacy benefit managers, beneficiaries, information exchange networks, technology experts, and representatives of the Departments of Veterans Affairs and Defense and other interested parties. The standards developed or adopted by the Secretary must be consistent with the objective of improving patient safety and improving the quality of care.

The standards for transactions, and data elements for these transactions, must provide that prescriptions, written and transmitted electronically, must comply with the standards except in emergency cases. The standards would accommodate the electronic transmittal of a patient's medication history, eligibility, benefit and other prescription information among prescribing and dispensing professionals at the point of care. The information that could be transmitted using the standards would include information on the drugs prescribed for the patient, cost-effective alternatives (if any) to the drug prescribed, information on eligibility and benefits, including the drugs included in the applicable formulary and any requirements for prior authorization. This information would also include information on potential drug interactions, and other information to improve the quality of care, to reduce medical errors, and contain costs. The standards shall be designed so that, to the extend practicable, they do not impose an undue administrative burden on the practice of medicine, pharmacy, or other health professions.

The standards developed or adopted by the Secretary would be compatible with and are required to safeguard the privacy of any individually identifiable information in a manner consistent with
the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

The Secretary would adopt standards for the exchange of appropriate and necessary information among precribing and insurance entities and other necessary entities. Prescribers and health plans would have to provide a written prescription, without any additional charges, if the patient requested one. In addition to the consultation requirements of Section 1172, the Secretary would be required to consult with the Attorney General to ensure that the standards resulted in the secure electronic transmission of prescriptions for controlled substances.

The Secretary would have to adopt the standards by Jan. 1, 2006, and would be permitted to modify them, but in a manner that minimized the disruption and cost of compliance. No individual or entity would be required to transmit or receive prescriptions electronically, but those that did would be required to comply with the standards. Entities covered by the standards would have 24 months to comply. Small health plans, as defined by the Secretary, would have an additional 12 months to comply.

The new Section 1180A would authorize the Secretary to award grants to health care providers to implement electronic prescription programs. There would be authorized to be appropriated such sums as may be necessary for each of fiscal years 2006, 2007, and 2008.

Effective Date. Effective upon enactment.

Subtitle D - Other Provisions

Section 131. Additional Requirements for Annual Financial Report and Oversight on Medicare Program

Current Law

The trustees of the Medicare Hospital Insurance trust fund and the Medicare Supplementary Medical Insurance trust fund are required to submit annual reports to the Congress.

Explanation of Provision

The provision would require the trustees to submit a combined report on the status of the two trust funds including the Prescription Drug Account. The report would include a statement of the

total amounts obligated during the preceding fiscal year from the General Revenues of the Treasury and the percentage such amount bore to all other obligations of the Treasury in that year. This calculation would be made separately for Medicare benefits and for administrative and other expenses. This information would be provided for each year beginning with the inception of Medicare. Ten-year and 50-year projections would also be required. The report would also provide a comparison of the rates of growth for both benefits and administrative costs to the rates of growth in the gross domestic product, health insurance costs in the private sector, employment-based health insurance costs in the public and private sectors, and other areas as determined appropriate by the Board of Trustees.

The section would express the sense of the Congress that the committees of jurisdiction would hold hearings on these reports.

Effective Date

The provision would apply with respect to fiscal years beginning on or after the date of enactment.

TITLE II - MedicareAdvantage
SUBTITLE A - MedicareAdvantage Competition

Section 201. Establishment of the MedicareAdvantage Program

Current Law

Eligibility. Medicare beneficiaries who are entitled to Part A of Medicare and enrolled in Part B may receive Medicare benefits through the original Medicare fee-for-service (FFS) program or they may enroll in a Medicare+Choice (M+C) plan.

Information requirements. The Secretary must provide information to Medicare beneficiaries and prospective beneficiaries on the coverage options provided under the M+C program, including open season notification, a list of plans and other general information.

M+C Elections. When the M+C program was implemented, individuals were able to make and change election to an M+C plan on an ongoing basis. Beginning in 2005, elections and changes to elections will be available on a more limited basis. Individuals can make or change elections during the annual coordinated election period (November 15th through December 31st for 2003 and 2004, and the month of November, thereafter). Current Medicare beneficiaries may also change their election at any time during the first 6 months of 2005 (or first 3 months of any subsequent year). Additionally, there are special enrollment rules for newly eligible aged beneficiaries as well as special enrollment periods for all enrollees in under limited situations such as an enrollee who changes place of residence.

Explanation of Provision

General. This provision would establish the MedicareAdvantage (MA) program, which would replace the 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) or a Private Fee-for-Service Plan (PFFS), or a regional Preferred Provider Organization (PPO). The statutory requirements for plans would remain largely the same, with modifications to reflect the new Medicare Part D drug benefit, requirements for enhanced benefits, and other changes.

Eligibility. 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.

Information requirements. In addition to information that the Secretary must disseminate under current law, he or she would also be required provide the following information about MA plans: 1) the MA monthly basic beneficiary premium, 2) the monthly beneficiary premium for enhanced medical benefits, 3) the MA monthly beneficiary obligation for qualified prescription drug coverage, 4) any beneficiary liability for balance billing under Medicare FFS, 5) the catastrophic coverage amount (including the maximum limitation on out-of-pocket expenses) and unified deductible for the plan, 6) the outpatient prescription drug coverage benefits, 7) any beneficiary cost sharing, including information on the unified deductible, 8) comparative information relating to prescription drug coverage, and 9) if applicable, any reduction in Medicare the Part B premium. Additionally in November 2005, the Secretary would conduct a special information campaign to inform MA eligible individuals about plans.

M+C Elections. Medicare beneficiaries would retain their ability to make and change elections to an MA plan through 2005. The current law limitation on changing elections that begins in 2005, would be delayed until 2006. Further, the annual coordinated election period for 2003 through 2006 would begin on November 15th and end on December 31st. Beginning in 2007, the annual coordinated election period would be during the month of November.

Section 202. Benefits and Beneficiary Protections

Current Law

Benefits. M+C plans are required to include all Medicare-covered services. In some circumstances, plans may also be required to offer additional benefits or reduced cost sharing to their beneficiaries. The *basic* benefit package includes all of the Medicare-covered benefits (except hospice services) as well as the additional benefits, as determined by a formula which is set in law. The adjusted community rate (ACR) mechanism is the process through which health plans determine the minimum amount of additional benefits they are required to provide to Medicare enrollees and the cost sharing they are permitted to charge for those benefits. Medicare does not currently have

a catastrophic limit.

Information requirements. An M+C organization must disclose, in clear, accurate and standardized form to each new enrollee and at least annually thereafter, certain information regarding the plan. The information includes service area, benefits, access, out-of-area coverage, emergency coverage, supplemental benefits, prior authorization rules, grievance and appeals procedures, a description of the quality assurance program, and other information upon request.

Quality Assurance Program. M+C plans must have a quality assurance program that: 1) stresses health outcomes and provides data permitting measurement of outcomes and other indices of quality; 2) monitors and evaluates high volume and high risk services and the care of acute and chronic conditions; 3) evaluates the continuity and coordination of care that enrollees receive; 4) is evaluated on an ongoing basis as to its effectiveness; 5) includes measures of consumer satisfaction, and 6) provides the Secretary with certain information to monitor and evaluate the plan's quality.

Explanation of Provision

Benefits. Each MA plan (except an MSA) would be required to offer: 1) all Medicare Parts A and B benefits (except hospice care) available to individuals residing in the area serviced by the plan, 2) qualified prescription drug coverage under Part D available to individuals residing in the area, 3) a maximum limitation on out-of-pocket expenses and a unified deductible, and 4) any required enhanced benefits. Additionally plans could choose to provide individuals with enhanced medical benefits that the Secretary could approve. The Secretary could deny any submission for an enhanced plan believed to attract a healthier population. The Secretary could not approve any enhanced medical benefit that provided for the coverage of any prescription drug, other than those relating to covered prescription drugs under Part D.

Information requirements. In addition to information that plans must disseminate under current law, they would also be required to provide the following information: 1) the maximum limitation on out-of-pocket expenses and the unified deductible, 2) qualified prescription drug coverage under Part D, and 3) enhanced medical benefits and the monthly beneficiary premium amount for the enhanced medical benefits.

Quality Assurance Program. In addition to current law requirements for quality assurance, the quality assurance programs of an organization (other than a PFFS plan or nonnetwork MSA) would also be required to provide disease management and chronic care services and to provide access to preventive benefits and information for enrollees on such benefits.

Section 203. Payments to MedicareAdvantage Organizations

Current Law

Payments. M+C plans are paid an administered monthly payment amount, (M+C payment

rate), for each enrollee. The payment area rate is the highest of one of three amounts: 1) a minimum payment (floor) rate, 2) a blend of an area-specific (local) rate and a national rate, or 3) a minimum increase from the prior year's rate. Each year, the three payment amounts are updated by formulas set in statute. Both the floor and the blend are updated by a measure of growth in program spending, the national growth percentage. The minimum increase is 2% over the prior year's amount.

After preliminary M+C payment rates are determined, a budget neutrality adjustment is required to determine final payment rates. This adjustment is made so that estimated total M+C payments in a given year will be equal to the total payments that would be made if payments were based solely on area-specific rates. The budget neutrality adjustment can only be applied to the blended rates because rates cannot be reduced below the floor or minimum increase amounts. The blend payment is also adjusted to remove the direct and indirect costs of graduate medical education.

Risk Adjustment. M+C payments are risk-adjusted to reflect variations in the cost of providing health care among Medicare beneficiaries. Currently a risk adjustment system is being phased in that adjusts payments based on inpatient data using the 15 principal inpatient diagnostic cost groups (PIP-DCGs) adjuster and demographic factors, so that this system accounts for both demographic and health-status variations. Under this mechanism, the per capita payment made to a plan for an enrollee is adjusted if that enrollee had an inpatient stay during the previous year. Separate demographically-based payments are used for enrollees without a prior hospitalization, newly eligible aged persons, newly eligible disabled Medicare enrollees, and others without a medical history. This system will be replaced with a more comprehensive risk adjustment mechanism beginning in 2004. The new risk adjustment methodology will be phased-in based on data from inpatient hospitals and ambulatory settings, at the rate of 30% in 2004, 50% in 2005, and 75% in 2006. Beginning in 2007, risk adjustment will be based entirely on data from inpatient hospitals and ambulatory settings.

Explanation of Provision

Payments. The Secretary would pay each MA organization, for coverage of an individual for a month, a separate payment for benefits under the Parts A and B, and for benefits under the voluntary prescription drug program. Each year the Secretary would calculate a benchmark amount for each MA payment area for each month with respect to coverage of benefits available under Medicare FFS. For plans participating on a county basis, the benchmark would be the greater of 1/12 of the annual M+C capitation rate for the payment area for the year or the local fee-for-service rate. The local fee-for-service rate would be defined as the amount of payment for a month in a 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. In calculating the local fee-for-service rate, adjustments would be made to remove the costs for indirect medical and direct graduate medical education.

Beginning in 2005, the Secretary would annually announce (at the same time as the announcement for risk adjustors for the prescription drug program - no later than April 15th of each

year) the following payment factors: the benchmark amount for each MA payment area and the factors to be used for adjusting payments under the comprehensive risk adjustment methodology.

For payments before 2006, the payment would be the same as under current law - the highest of the blend, minimum amount (floor), or minimum update. Beginning in 2014, the minimum amount (floor) would be annually updated by the percentage increase in the Consumer Price Index for all urban consumers for the 12-month period ending with June of the previous year. The Secretary would calculate and publish the annual M+C capitation rates and would use those rates for purposes of determining the benchmark amount.

Beginning in 2006, MA plans would be paid based on the following new methodology. First, each plan would submit a bid (see sec. 204, below) including assumptions with respect to the number of enrollees. The Secretary would calculate a weighted service area benchmark amount for the benefits under FFS for each plan equal to the weighted average of the benchmark amounts for benefits under Medicare FFS for the payment areas included in the service are of the plan, using assumptions contained in the plan bid with respect to the numbers of enrolled individuals. The Secretary would determine the difference between each plan bid and the weighted service area benchmark amount for purposes of determining the payment amount to plans, any required additional benefits and the MA monthly basic beneficiary premium. The Secretary 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 less 25% of the difference between the two, further reduced by the amount of any premium reduction elected by the plan. For purposes of adjusting plan bids and benchmarks, with respect to FFS benefits, the Secretary would use the benchmark for the MA payment area, adjusted by the health status and other demographic factors of the MA payment area, as well as the risk adjusters for prescription drug benefits.

Risk Adjustment. This provision would modify risk adjustment in 2005, so that the Secretary would apply the comprehensive risk adjustment methodology to 100% of the amount of payments to plans. This would apply to all types of plans beginning in 2006. Organizations would be required to submit data and other information, in order to carry out risk adjustment. The Secretary could revise the comprehensive risk adjustment methodology from time to time to improve payment accuracy.

Section 204. Submission of Bids; Premiums

Current Law

The Public Health Security and Bioterrorism Preparedness and Response Act of 2002, P.L. 107-188, temporarily moved plan deadlines for submitting ACRs and other information from no later than July 1 to no later than the second Monday in September for 2002, 2003, and 2004.

Each year an M+C organization submits an adjusted community rate (ACR) proposal, estimating their proposed cost of serving Medicare beneficiaries for the following contract year. The ACR process is a mechanism through which health plans determine the minimum amount of additional benefits they are required to provide to Medicare enrollees and the cost sharing they are permitted to charge for those benefits. Under Medicare's rules, a plan may not earn a higher return from its Medicare business than it does in the commercial market. The Secretary reviews this information and approves or disapproves the premiums, cost-sharing amounts, and benefits. The Secretary does not have the authority to review the premiums for either MSA plans or private fee-for-service plans.

Beneficiaries share in any projected cost savings between Medicare's per capita payment to a plan and what it would cost the plan to provide Medicare benefits to its commercial enrollees. To accomplish this, plans must provide either reduced cost sharing or additional benefits to their Medicare enrollees that are valued at the difference between the projected cost of providing Medicare-covered services and the expected revenue for Medicare enrollees. Additionally, beginning in 2003, plans may also reduce the Medicare part B premium. Plans can choose which additional benefits to offer, however, the total cost of these benefits must at least equal the "savings" from Medicare-covered services. Plans may also place the additional funds in a stabilization fund or return funds to the Treasury.

Cost sharing. The actuarial value of deductibles, coinsurance, and copayments applicable on average to individuals enrolled in an M+C plan for required services may not exceed the actuarial value of deductibles, coinsurance, and copayments on average for individuals in traditional Medicare. However, this average may be achieved by having higher copayments for some M+C services and lower for other services.

Explanation of Provision

Each MA organization would be required to submit information by the 2nd Monday in September, including: 1) notice of intent and information on the service area of the plan, 2) the plan type for each plan, 3) specific information for coordinated care and PFFS plans, 4) enrollment capacity, 5) the expected mix, by health status of enrolled individuals, and 6) other information required by the Secretary. For coordinated care plans and PFFS plans, the plans would be required to submit the plan bid (the total amount that the plan is willing to accept for FFS benefits), the assumptions used in preparing the bid with respect to the number of enrollees in each payment area and the mix by health status, and any required information for prescription drug coverage. For any enhanced medical benefit package a plan chooses to offer, it would be required to provide the following information: 1) the adjusted community rate, 2) the MA monthly beneficiary premium for enhanced benefits, 3) cost-sharing requirements, 4) the description of whether the unified deductible had been lowered or if the maximum out-of-pocket limitation had been decreased, and 5) other information required by the Secretary. Each plan bid would be required to reasonably and equitably reflect the cost of benefits provided under that plan.

The monthly amount of the premium, if any, charged to an MA enrollee would be the sum of any MA monthly basic beneficiary premium, any premium for enhanced medical benefits and any obligation for prescription drug coverage. If the weighted service area benchmark exceeded the plan bid, the Secretary would require the plan to provide additional benefits, and if the plan bid exceeded the weighted service area benchmark, the plan could charge an MA monthly basic beneficiary premium.

If the plan bid was lower than the plan benchmark, if the plan could, in addition to benefits allowed under current law, also lower the amount of the unified deductible and decrease the maximum limitation on out-of-pocket expenses. However, plans would be restricted from specifying any additional benefits that provided for the coverage of any prescription drug, other than that relating to covered drugs under Part D.

Cost Sharing. The monthly basic beneficiary premium and the actuarial value of the deductible, coinsurance and copayments (taking into account any cost-sharing reduction), would have to equal to the actuarial value of the deductible, coinsurance and copayments applicable on average to individuals who elected to receive benefits under FFS, if such individual were not a member of an MA organization (adjusted to account for geographic differences and for the plan cost and utilization differences). Similarly for enhanced medical benefits, the sum of the MA monthly beneficiary premium for enhanced medical benefits and the actuarial value of the deductible, coinsurance, and copayments, must equal the Adjusted Community Rate (ACR) for such benefits for the year.

Section 205. Special Rules for Prescription Drug Benefits

Current Law

No provision.

Explanation of Provision

This provision would establish the rules for prescription benefits for M+C enrollees. Beginning on January 1, 2006, MA plans would be required to offer each enrollee qualified prescription drug coverage that met the requirements for such coverage under the MA program and under Part D of Medicare. An MA plan could offer qualified prescription drug coverage that exceeded the coverage required under the Part D, as long as it also offered an MA plan in the area that provided only the required coverage.

Section 206: Special Rules for Employer Sponsored Plans

Current Law

Empoyers may sponsor a Medicare+Choice plan or pay premiums for retirees who enroll in

a Medicare+Choice plan. If a Medicare+Choice plan contracts with an employer group health plan (EGHP) that covers enrollees in an M+C plan, the enrollees must be provided the same benefits as all other enrollees in the M+C plan, with the EGHP benefits supplementing the M+C plan benefits. The Secretary may waive or modify requirements that hinder the ability of employer or union group health plans from offering a M+C plan option.

Explanation of Provision

Employers would be permitted to sponsor a MA plan or pay premiums for qualified retirees who enroll in a MA plan. If a MA plan contracts with an employer group health plan that covers enrollees in a MA plan, the enrollees must be provided the same benefits as all other enrollees in the MA plan, with the EGHP benefits enhancing the MA plan benefits. The Secretary may waive or modify requirements that hinder the ability of employer or union group health plans from offering a MA plan option.

Section 207: Administration by the Center for Medicare Choices

Current Law

The M+C program is currently administered by the Centers for Medicare and Medicaid Services (CMS).

Explanation of Provision

Beginning January 1, 2006, the MA program would be administered by the Center for Medicare Choices, and each reference to the Secretary made shall be deemed to be a reference to the Administrator of the Center for Medicare Choices.

Section 208. Conforming Amendments

Current Law

Contracts between M+C organizations and CMS are subject to statutory requirements.

Explanation of Provision

The Secretary could determine that an MA organization failed to meet the terms of its contract. In addition to specifications included in current law, an organization would also not be allowed to charge any individual an amount in excess of the MA monthly beneficiary obligation for qualified prescription drug coverage, provide coverage that is not qualified prescription drug coverage, offer prescription drug coverage but not make standard prescription drug coverage available, or provide coverage for drugs other than that relating to prescription drugs covered under Part D as an enhanced or additional benefit.

Section 209. Effective Date

Current Law

No provision.

Explanation of Provision

Effective January 1, 2006. However, the Secretary would apply payment and other rules for MSA plans, as if this title had not been enacted

SUBTITLE B-PREFERRED PROVIDER ORGANIZATIONS

SEC. 211. Establishment of MedicareAdvantage Preferred Provider Program Option

Current Law

PPOs are permitted to be offered as coordinated care plans under the Medicare+Choice program.

Explanation of Provision

Beginning January 1, 2006, a preferred provider organization (PPO) plan would be offered to MA eligible individual in preferred provider regions. A PPO would be an entity with a contract that is not licensed or organized under State law as an HMO and that met other requirements of this Act. A PPO would have a network of providers that agreed to contractually specified reimbursements for covered benefits under Parts A and B.

There would be at least 10 regions. Each region would have to include at least 1 state. The Secretary could not divide states so that portions of the state were in different regions. To the extent possible, the Secretary would include multi-state metropolitan statistical areas (MSAs) in a single region, except that he or she could divide an MSA where necessary to establish a region of such size and geography to maximize the participation of PPOs. The Secretary could use the same regions established for the prescription drug program, under Part D. The service area of a PPO would be the region. The Secretary could disapprove any PPO believed to attract a population that is healthier than the average population of the region serviced by the plan. PPOs would be required to establish a sufficient number of contracts and agreements with a sufficient range of providers to demonstrate beneficiary access, as required under for county-based coordinated care plans.

The Secretary would make separate monthly payment with respect to benefits under FFS and benefits under the voluntary prescription drug program under part D. The Secretary would establish

separate rates of payment for individuals with ESRD. The Secretary would apply the comprehensive risk adjustment methodology to 100% of the plan payment. The Secretary would also establish a methodology for adjusting the payments to plan to ensure that the amount paid on behalf of an MA eligible individual did not exceed that amount that would have been paid if the individual had been enrolled in a coordinated care plan, or a PFFS plan.

Beginning in 2006, the Secretary 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. The Secretary would further adjust these rates by the comprehensive risk adjustment factor and an adjustment for spending variation within a region. Each year, beginning in 2005, the Secretary would publish (at the time of publication of the risk adjustors under Part D - no later than April 15th) the benchmark amount for each region, factors to be used for adjusting payments under the comprehensive risk adjustment methodology and the inter-region spending adjustor.

Each plan would submit a bid for coverage of required benefits, with assumptions about the number of enrollees. The Secretary would adjust each plan bid based on the plans assumptions about enrollment. The Secretary would calculate a regional benchmark amount for each plan equal to the regional benchmark adjusted for the number of enrollees assumed in the plan bid. The Secretary would determine the difference between each adjusted plan bid and the plan's regional benchmark amount to determine the payment amount, additional of benefits required, and the MA monthly basic beneficiary premium.

The Secretary would pay plans as follows: 1) for bids that equal or exceed the plan benchmark, the MA organization would receive the plan benchmark amount and 2) for bids below the plan benchmark, the plan would receive the plan benchmark less 25% of the difference between the plan bid and plan benchmark, further reduced by the amount of any premium reduction elected by the plan.

No later than the second Monday in September, a PPO would have to submit notice of intent, information on which region the plan is bidding, and information similarly required for other MA plans. The PPO would also have to indicate the total amount the plan is willing to accept after application of risk adjustment, geographic variation, and for 2006 and 2007 risk corridors. The Secretary shall limit the number of plans in a region to the three lowest-cost credible plans that meet or exceed the quality or minimum standards. The monthly premium charged to an enrollee would equal the sum of any MA monthly basic beneficiary premium, any MA monthly beneficiary premium for enhanced medical benefits, and any MA monthly obligation for qualified prescription drug coverage. Unlike other MA plans, PPOs would not be permitted to segment a region.

The PPO would notify the Secretary of the total amount of costs incurred during 2006 and 2007 in providing covered benefits under Part A and B of Medicare, except that certain expense would not be included (administrative expenses over the amount determined appropriate by the Administrator and amounts expended for enhanced medical benefits).

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. If the total amount of costs for the year were not more than the first hreshold upper limit of the risk corridor, then no additional payment would be made (or conversely, if total costs were not less than the first threshold lower limit, no reduced payment would be made). If the total amount of costs for the plan were more than the first threshold, the plan would receive 50% of the amount of costs above the first threshold up to the second threshold, and 10% of the costs that were more than the second threshold. Similarly if costs were less, the payment would be reduced by 50% of the amount such total costs were less than the first threshold lower limit and not less than the second threshold, and 10% of the amount such costs were less than the second threshold. For 2006 and 2007, the first threshold lower limit would be the target amount minus 5% of the target, and the second threshold would be the target amount minus 10% of the target. For the upper limit , the first threshold upper limit would be the target amount plus 5%, and the second threshold would be the target amount plus 10%. The target amount would be defined as an amount equal to the sum of total monthly payments made to the organization for plan enrollees for the year and the total MA basic beneficiary premium for such enrollees. PPOs would be at full risk for all enhanced medical benefits. A beneficiary's liability would not be affected by these risk corridors in the given years.

SUBTITLE C - Other Managed Care Reforms

Section 221. Extension of Reasonable Cost Contracts

Current Law

Cost-based plans are reimbursed by Medicare for the actual cost of furnishing covered services, less the estimated value of beneficiary cost-sharing. The Secretary can not extend or renew a reasonable cost reimbursement contract for any period beyond December 31, 2004.

Explanation of Provision

This provision would allow a reasonable cost contract to be extended or renewed until December 31, 2009. Beginning in 2004 these plans would have to comply with certain provisions of the M+C program (and beginning in 2006 the MA program), including provisions relating to ongoing quality assurance programs, limitations on physician incentive plans, requirements of uniform premium amounts for individuals enrolled in the plan, restrictions on the imposition of premium taxes, compliance with standards established by regulation - including provisions relating to state law, the authority of organizations to include supplemental health care benefits subject to the Secretary's approval, provisions of Part C relating to timelines for benefit fillings, contract renewals and beneficiary notifications, and proposed cost-sharing under the contract being subject to review by the Secretary.

Section 222. Specialized Medicare+Choice Plans for Special Needs Beneficiaries

Current Law

One model for providing a specialized M+C plan, EverCare, operates as a demonstration program. EverCare, is designed to study the effectiveness of managing acute-care needs of nursing home residents by pairing physicians and geriatric nurse practitioners. EverCare, receives a fixed capitated payment, based on a percentage of the AAPCC, for all nursing home resident Medicare enrollees.

Explanation of Provision

This provision would establish a new M+C option – specialized M+C plans for special needs beneficiaries (such as the EverCare demonstration). Special needs beneficiaries are defined as those M+C eligible individuals who are institutionalized, entitled to Medicaid, or meet requirements determined by the Secretary. Enrollment in specialized M+C plans could be limited to special needs beneficiaries until January 1, 2008. No later than December 31, 2006 the Secretary would be required to submit a report to Congress that assessed the impact of specialized M+C plans for special need beneficiaries on the cost and quality of services provided to enrollees. No later than 1 year after

enactment of this Act, the Secretary would be required to issue final regulations to establish requirements for special needs beneficiaries.

Section 223. Payment by PACE Providers for Medicare and Medicaid Services Furnished by Contract Providers

Current Law

The Program of All-Inclusive Care for the Elderly (PACE) was created as a demonstration project in Omnibus Reconciliation Act (OBRA) 86. The Secretary was required to grant waivers of certain Medicare and Medicaid requirements to a maximum of 10 (expanded to 15 in OBRA 90) community-based organizations to provide health and long-term care services on a capitated basis to frail elderly persons at risk of being institutionalized. BBA of 1997 made PACE a permanent part of Medicare and a state option for the Medicaid program.

Explanation of Provision

For the Medicare program, this provision would apply limitations on balance billing to PACE providers, individuals enrolled with such PACE providers, and noncontract physicians and other entities in the same manner as applies to M+C organizations, individuals enrolled with such organizations, and physicians and other entities. For the Medicaid program, with respect to services covered under the State plan (but not under Medicare) that are furnished to an individual enrolled in a PACE program. The PACE program would not be required to pay a provider an amount greater than required under the State plan.

TITLE III- CENTER FOR MEDICARE CHOICES

SECTION 301. ESTABLISHMENT OF THE CENTER FOR MEDICARE CHOICES

Current Law

The authority for administering the Medicare program resides with the Secretary of Health and Human Services. The Secretary originally created the agency that administers the Medicare and Medicaid programs in 1977 under his administrative authority. Regulations regarding Medicare are required to be promulgated by the Secretary. The Medicare statute requires that the Administrator of the Centers for Medicare & Medicaid Services (CMS formerly known as the Health Care Financing Administration) be appointed by the President with the advice and consent of the Senate. Title 5 of the U. S. Codes sets the Administrator's salary at level IV of the Executive Schedule.

Explanation of Provision

The section would amend title XVIII to add new section 1808 which, under subsection (a), would establish a new Center for Medicare Choices (CMC) within the Department of Health and Human Services by no later than March 1, 2004 to administer parts C and D of Medicare.

Subsection (b)would provide for an Administrator of the CMC both who would be appointed by the President with the advice and consent of the Senate for 5-year terms. The Administrator would be able to appoint a Deputy Administrator. If a successor did not take office at the end of the term, the Administrator would continue in office until the successor enters the office. In that event, the confirmed successor's term would be the balance of the 5-year period. The Administrator would be paid at level III of the Executive Schedule and the Deputy Administrator at level IV of the Executive Schedule. The Administrator would be responsible for the exercise of all powers and the discharge of duties of the CMC and has authority and control over all personnel. The provision would permit the Administrator to prescribe such rules and regulations as the Administrator determined necessary or appropriate to carry out the functions of CMC, subject to the Administrative Procedure Act. The Administrator would be able to establish different organizational units within the CMC except for any unit, component, or provision provided by section 1808. The Administrator may assign duties, delegate, or authorize redelegations of authority to CMC officers and employees as needed. The Secretary of Health and Human Services shall ensure appropriate coordination between the Administrator of CMC and the Administrator of the Centers for Medicare & Medicaid Services in administering the Medicare program.

Subsection (c) would prescribe the duties of the Administrator and administrative provisions relating to the CMC. In administering parts C and D of Medicare, the Administrator would be required to negotiate, enter into and enforce contracts with MedicareAdvantage plans and with eligible entities for Medicare prescription drug plans. The Administrator would be required to carry out any duty provided for under part C or D of Medicare including demonstration programs (that are carried out in whole or in part under parts C or D). The Administrator of the agency, to the extent possible, would not be able interfere in any way with negotiations between eligible entities, MedicareAdvantage organizations, hospitals, physicians, other entities or individuals furnishing items and services under this title (including contractors for such items and services), and drug manufacturers, wholesalers, or other suppliers of covered drugs. The Administrator would be required to submit a report to Congress and the President on the administration of the voluntary prescription drug delivery program not later than March 31 of each year.

The Administrator, with the approval of the Secretary, would be able to employ management staff as determined appropriate. The Administrator would be able to compensate such managers up to the highest rate of basic pay for the Senior Executive Service. Any such manager would be required to have demonstrated, by their education and experience (either in the public or private sectors) superior expertise in the review, negotiation, and administration of

health care contracts, the design of health care benefit plans, actuarial sciences, compliance and health plan contracts, consumer education and decision-making.

Subsection (d) would require the Secretary to establish an Office of Beneficiary Assistance within CMC to make Medicare eligibility determinations, enroll beneficiaries into Medicare, provide Medicare benefit and appeals information, and carry out any other activities relating to Medicare beneficiaries under title XVIII. Within the Office of Beneficiary Assistance, a Beneficiary Ombudsman would be established who is appointed by the Secretary. The Ombudsman would be required to receive complaints, grievances, and requests for information submitted by a Medicare beneficiary regarding any aspect of the Medicare program; to provide assistance with the complaints, grievances and requests including assisting beneficiaries with appeals; and with problems arising from disenrolling from a MedicareAdvantage plan or a prescription drug plan. The Ombudsman would be required to submit annual reports to Congress, the Secretary, and the Medicare Competitive Policy Advisory Board describing the activities of the Ombudsman's office and including any recommendations for improvement in the administration of title XVIII. The Ombudsman would also be required to coordinate with state medical ombudsmen programs, and with state-and community-based consumer organizations to provide information about the Medicare program and to conduct education outreach regarding resolution or avoidance of problems under the Medicare program.

Subsection (e) would establish the Medicare Competitive Policy Advisory Board (the Board) within the CMC to advise, consult with, and make recommendations to the Administrator regarding the administration and payment policies of parts C and D. The Board would be required to report to Congress and to the Administrator of CMC such reports as the Board determines appropriate and may contain recommendations that the Board considers appropriate regarding legislative or administrative changes to improve the administration of parts C and D including: stability and solvency of the program, increasing competition, improving the quality of benefits, incorporating disease management, improving competition and access to plans in rural areas, and improving beneficiary information and education for the entire Medicare program. The reports would be required to be published in the *Federal Register*. The reports would be submitted directly to Congress and no officer or agency of the government would be allowed to require the Board to submit a report for approval, comments, or review prior to submission to Congress. Not later than 90 days after a report is submitted to the Administrator, the Administrator would be required to submit to Congress and the President an analysis of the recommendations made by the Board. The analysis would be required to be published in the *Federal Register*. The Administrator of CMC is required to provide information and assistance to the Board as is requested to carry out its functions.

The Board would be made up of 7 members serving three-year terms, with three members appointed by the President, two appointed by the Speaker of the House of Representatives, and two appointed by the President pro tempore of the Senate. Board members may be reappointed but may not serve for more than 8 years. The Board shall elect the Chair to serve for three years. The Board is required to meet at least three times a year and at the call of the Chair. The Board

is required to have an executive director who, with the approval of the Board, may appoint staff as appropriate.

Subsection (f) authorizes an appropriation of such sums as are necessary from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (including the Prescription Drug Account) to carry out section 1808.

SECTION 302. MISCELLANEOUS ADMINISTRATIVE PROVISIONS

Current Law

The Board of Trustees of the Medicare Trust Funds is composed of the Commissioner of Social Security, the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services and two members of the public. The Administrator of the Centers for Medicare & Medicaid Services serves as the Secretary of the Board of Trustees.

Title 5 of the U. S. Codes sets the Administrator's salary at level IV of the Executive Schedule.

Explanation of Provision

Subsection (a) would add the Administrator of CMC as Co-Secretary of the Board of Trustees of the Medicare Trust Funds.

Subsection (b) would increase the pay level for the Administrator of CMS from level IV of the Executive Schedule to level III.

Effective Date

The CMC would be required to be established by the Secretary no later than March 1, 2004.

TITLE IV – MEDICARE FEE-FOR-SERVICE PROVISIONS

Subtitle A – Provisions Relating to Parts A

TITLE IV – MEDICARE FEE-FOR-SERVICE PROVISIONS

Subtitle A – Provisions Relating to Part A

Section 401. Equalizing Urban and Rural Standardized Payment Amounts Under the Medicare Inpatient Hospital Prospective Payment System.

Current Law

Medicare pays for inpatient services in acute hospitals in large urban areas using a standardized amount that is 1.6% larger than the standardized amount used to reimburse hospitals in other areas (both rural areas and smaller urban areas). The Consolidated Appropriations Act of 2003 (PL.108-7) provided for a temporary payment increase for rural and small urban hospitals; all Medicare discharges from April 1, 2003, to December 31, 2003, will be paid on the basis of the large urban area amount.

Explanation of Provision

Beginning for discharges in FY2004, the Secretary would compute a standardized amount equal to that for hospitals in large urban areas to pay hospitals in any area within the United States.

Effective Date

Upon enactment.

Section 402. Adjustment to the Medicare Inpatient Hospital PPS Wage Index to Revise the Labor-Related Share of Such Index.

Current Law

Medicare's payments to acute hospitals are adjusted, either increased or decreased as appropriate, by the wage index of the area where the hospital is located or where it has been reassigned. Presently, approximately 71% of a the standardized amount for each hospital discharge is adjusted by the area wage index. Decreasing this proportion or labor-related share would increase Medicare payments to hospitals in areas with wage indices below one and decrease Medicare payments to hospitals in areas with wage indices above one.

Explanation of Provision

For cost reporting periods beginning on or after October 1, 2003, the Secretary would be required to decrease the labor-related share to 62% of the standardized amount only if such change would result in higher total payments to the hospital. This provision would be applied without regard to certain budget-neutrality requirements.

Effective Date

Upon enactment.

Section 403. Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals.

Current Law

Medicare pays inpatient acute hospital services on a discharge basis without regard for the number of beneficiaries discharged from any given hospital. Under certain circumstances, however, sole community hospitals (SCHs) and Medicare dependent hospitals with more than a 5% decline in total discharges from one period to the next may apply for an adjustment to their payment rates to partially account for higher costs associated with a drop in patient volume due to circumstances beyond its control.

Explanation of Provision

The provision would require the Secretary to develop a graduated adjustment to Medicare's inpatient payment rates to account for the higher unit costs associated with low-volume hospitals. Certain hospitals with fewer than 2,000 total discharges during the 3 most recent cost reporting periods would be eligible for up to a 25% increase in their Medicare payment amount starting for FY2005 cost reporting periods. Eligible hospitals would be located

at least 15 miles from a similar hospital or those determined by the Secretary to be so located due to factors such as weather conditions, travel conditions, or travel time to the nearest alternative source of appropriate inpatient care. Certain budget- neutrality requirements would not apply to this provision.

Effective Date

Upon enactment.

Section 404. Fairness in the Medicare Disproportionate Share Hospital (DSH) Adjustment for Rural Hospitals.

Current Law

Medicare makes additional payments to certain acute hospitals that serve a large number of low-income Medicare and Medicaid patients. As specified by BIPA, starting with discharges occurring on or after April 1, 2001, all hospitals are eligible to receive Medicare disproportionate share hospital (DSH) payments when their DSH patient percentage or threshold amount exceeds 15% Different formulas are used to establish a hospital's DSH payment adjustment, depending upon the hospital's location, number of beds and status as a rural referral center (RRC) or sole community hospital (SCH). Although a SCH or RRC can qualify for a higher DSH adjustment, generally, the DSH adjustment that a small urban or rural hospital can receive is limited to 5.25%. Large (100 beds and more) urban hospitals and large rural hospitals (500 beds and more) are eligible for a higher adjustment that can be significantly greater; the amount of the DSH adjustment received by these larger hospitals will depend upon its DSH percentage. Certain urban hospitals (Pickle hospitals) receive DSH payments under an alternative formula that considers the proportion of a hospital's patient care revenues that are received from state and local indigent care funds.

Explanation of Provision

Starting for discharges after October 1, 2003, a hospital that qualifies for a DSH adjustment when its DSH patient percentage exceeds the 15% DSH threshold would receive the DSH payments using the current formula that establishes the DSH adjustment for a large urban hospital. A Pickle hospital receiving a DSH adjustment under the alternative formula would not be affected.

Effective Date

The provision would apply to discharges occurring on or after October 1, 2003.

Section 405. Critical Access Hospital (CAH) Improvements.

(a) Permitting Hospitals to Allocate Swing Beds and Acute Care Inpatient Beds Subject to a Total Limit of 25 Beds.

Current Law

A CAH is a limited service facility that must provide 24-hour emergency services and operate a limited number of inpatient beds in which hospital stays can average no more than 96 hours. A CAH is limited to 15 acute-care beds, but can have an additional 10 swing beds that are set up for skilled nursing facility level care. While all 25 beds in a CAH can be used as swing beds, only 15 of the 25 can be used for acute care at any time.

Explanation of Provision

A CAH would be able to operate up to 25 swing beds or acute care beds. The requirement that only 15 of the 25 beds be used for acute care at any time would be dropped.

Effective Date

Upon enactment.

(b) Elimination of the Isolation Test for Cost-Based CAH Ambulance Services.

Current Law

Ambulance services provided by a CAH or provided by an entity that is owned or operated by a CAH is paid on a reasonable cost basis and not the ambulance fee schedule, if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of the CAH.

Explanation of Provision

The provision would drop the requirement that the CAH or the related entity be the only ambulance provider with a 35-mile drive in order to receive reasonable cost reimbursement for the ambulance services.

Effective Date

The provision would apply to services furnished on or after January 1, 2004.

(c) Coverage of Costs For Certain Emergency Room On-Call Providers.

Current Law

BIPA required the Secretary to include the costs of compensation (and related costs) of on-call emergency room physicians who are not present on the premises of a CAH, are not otherwise furnishing services, and are not on-call at any other provider or facility when determining the allowable, reasonable cost of outpatient CAH services.

Explanation of Provision

The provision would expand reimbursement of on-call emergency room providers to include physician assistants, nurse practitioners, and clinical nurse specialists as well as emergency room physicians for covered Medicare services provided on or after January 1, 2004.

Effective Date

The provision would apply to costs incurred for services on or after January 1, 2004.

(d) Authorization of Periodic Interim Payment (PIP).

Current Law

Eligible hospitals, skilled nursing facilities, and hospices which meet certain requirements receive Medicare periodic interim payments (PIP) every 2 weeks; these payments are based on estimated annual costs without regard to the submission of individual claims. At the end of the year, a settlement is made to account for any difference between the estimated PIP payment and the actual amount owed. A CAH is not eligible for PIP payments.

Explanation of Provision

Starting with payments made on or after January 1, 2004, an eligible CAH would be able to receive payments made on a PIP basis for inpatient services.

Effective Date

The provision would apply to payments for inpatient CAH services furnished on or after January 1, 2004.

(e) Exclusion of New CAHs from PPS Hospital Wage Index Calculation .

Current Law

Certain qualified small hospitals are converting to CAHs. After conversion, these facilities are paid on a reasonable cost basis and are not paid under the hospital inpatient prospective payment system (IPPS). Medicare's IPPS payments to acute hospitals are adjusted by the wage index of the area where the hospital is located or has been reassigned. Although the hospital wage index is recalculated annually, the wage index for any given fiscal year is based on data submitted as part of a hospital's cost report from 4 years previously. Presently wage data from hospitals that have converted to CAHs are included in the PPS wage index calculation.

Explanation of Provision

The Secretary would be required to exclude wage data from hospitals that have converted to CAHs from the PPS wage index calculation starting for cost reporting periods on or after January 1, 2004.

Effective Date

Upon enactment.

(f) Provisions Related to Certain Rural Grants.

Current Law

The Secretary is able to make grants for specified purposes to States or eligible small rural hospitals that apply for such awards. For example, the Medicare Hospital Flexibility Program awards grants to states for rural health care planning and implementation activities, rural network development and implementation, to establish or expand rural emergency medical services and for CAH designations.

The Secretary may also award grants to hospitals to assist eligible small rural hospitals in implementing data systems required under BBA 1997. Small rural hospitals are short term general hospitals with less than 50 beds that are located in rural areas. The authorization to award the grants expired in FY2002.

Explanation of Provision

The provision would permit the Secretary to award grants under the Small Rural Hospital Improvement Program to hospitals that have submitted applications to assist eligible small rural hospitals in reducing medical errors, increasing patient safety, protecting patient privacy, and improving hospital quality. These grants would not exceed $50,000 and would be able to be

used to purchase computer software and hardware, educate and train hospital staff, and obtain technical assistance. The provision would authorize appropriations of $40 million each year from FY2004 through FY2008 from the Federal Hospital Insurance Trust Fund for grants to States for specified purposes. States that are awarded grants would be required consult with the hospital association and rural hospitals in the state on the most appropriate way to use such funds. The provision would also authorize $25 million each year from FY2004 through FY2008 for the Small Rural Hospital Improvement Program. This amount would be appropriated from amounts in the treasury not otherwise appropriated.

Effective Date

The provisions would be effective upon enactment. They would apply to grants awarded on or after the date of enactment and would apply to grants awarded prior to the date of enactment to the extent that the funds have not yet been obligated.

Section 406. GAO Study and Report on Appropriateness and Need to Rebase Under the Prospective Payment System for Inpatient Hospital Services.

Current Law

No provision.

Explanation of Provision

The Comptroller General of the United States (GAO) would be required to use the most current data available to conduct a study to determine (1) the appropriate level and distribution of Medicare payments to short-term general hospitals under the inpatient prospective payment system (IPPS) and (2) the need for geographic adjustments to reflect legitimate differences in hospital costs. The study, including recommendations for necessary legislative and administrative action, would be due to Congress within 18 months of enactment.

Effective Date

Upon enactment.

Subtitle B – Provisions Relating to Part B

Section 411. Establishment of Floor on Geographic Adjustments of Payment for Physicians' Services.

Current Law

Medicare's payment for physicians' services under a fee schedule has three components: the relative value for the service, geographic adjustment factors and a conversion factor into a dollar amount. A service's relative value is made up of a physician work component, a practice expense component, and a malpractice expense component. Each of these is then adjusted by a separate geographic adjustment factor and combined together to calculate an indexed relative value for that service provided in a given location. This locality adjusted relative value unit is multiplied by the conversion factor to calculate Medicare's payment for a service provided by a physician in a given area.

The geographic adjustment factors are indices that reflect the relative cost difference in a given area in comparison to the national average. An area with costs above the national average would have an index greater than 1.00; alternatively, an area with costs below the national average would have an index less than 1.00. The physician work geographic adjustment factor is based on a sample of median hourly earnings in six professional specialty occupational categories. Unlike the other geographic adjustments, the work adjustment factor reflects only one-quarter of the cost differences in an area. The practice expense adjustment factor is based on employee wages, office rents, medical equipments and supplies, and other miscellaneous expenses. The malpractice adjustment factor reflects differences in malpractice insurance costs.

The Secretary is required to periodically review and adjust the relative values affecting physician payment to account for changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. Under the budget-neutrality requirement, changes in these factors cannot cause expenditures to differ by more than $20 million from what would have been spent if such adjustments had not been made.

Explanation of Provision

For services furnished after January 1, 2004, the Secretary would be required to increase the value of any work geographic index that is below .980 to .980. For services furnished after January 1, 2005, the values for work, practice expense and malpractice geographic indices in low value localities areas would be raised to 1.00 until 2008. The increase in expenditures resulting from the implementation of these floors would not be taken into account when applying the budget-neutrality requirement.

Effective Date

Upon enactment.

Section 412. Medicare Incentive Payment Program Improvements.

Current Law

Physicians providing services in a health professional shortage area (HPSA) are entitled to an incentive payment from the Medicare program. This incentive payment is a 10% increase over the amount which would otherwise be paid under the physician fee schedule.

Explanation of Provision

The Secretary would be required to establish procedures to determine when the physician is eligible for a bonus payment. The Secretary would also be required to (1) establish an ongoing program to educate physicians about the incentive program; (2) establish an ongoing study of the incentive program to determine whether beneficiaries' access to physician's services within the HPSA has improved; and (3) submit annual reports including appropriate recommendations for necessary administrative or legislative action concerning improvements to the program.

Effective Date

Upon enactment.

Section 413. Increase in Renal Dialysis Composite Rate For Services Furnished in 2003 and 2004.

Current Law

Dialysis facilities providing care to beneficiaries with end-stage renal disease (ESRD) receive a fixed prospectively determined payment amount (the composite rate) for each dialysis treatment. BBRA increased the composite rates by 1.2% for dialysis services furnished in both 2000 and 2001. BIPA subsequently increased the mandated 2001 update to 2.4%, an increase that was to implemented on the following schedule in order to avoid a disruption in claims processing: for services furnished from January through March, 2001, the 1.2% increase specified by BBRA applied; for the remainder of 2001, a transition increase of 2.79% applied. Effective January 1, 2002, the composite rates reflected the 2.4% increase.

Explanation of Provision

The composite rate would be increased by 1.6% for services furnished in 2004 and 2005.

Effective Date

Upon enactment.

Section 414. Extension of Hold Harmless Provision for Small Rural Hospitals; Treatment of Certain Sole Community Hospitals to Limit Decline in Payment Under the OPD PPS; Interim Payments and Study for Covered OPD Drugs and Biologics.

Current Law

The PPS for services provided by outpatient departments (OPD) was implemented in August 2000 for most acute care hospitals. Under hold harmless provisions, rural hospitals with no more than 100 beds are paid no less under this PPS system than they would have received under the prior reimbursement system for covered OPD services provided before January 1, 2004.

Explanation of Provision

The hold harmless provisions governing OPD reimbursement for small rural hospitals would be extended to January 1, 2006. These hold harmless provisions would be extended to sole community hospitals located in rural areas for services provided after January 1, 2004 and before January 1, 2006.

Effective Date

Upon enactment.

Section 415. Increase in Payments for Certain Services Furnished by Small Rural Hospitals Under Medicare Prospective Payment System for Hospital Outpatient Department Services.

Current Law

Under the OPD PPS, which was implemented in August, 2000, Medicare pays for covered services using a fee schedule based on ambulatory payment classifications (APCs). Beneficiary copayments are established as a percentage of Medicare's fee schedule payment and differ by APC. Certain hospitals, including rural hospitals with no more than 100 beds, are protected from financial losses that result from implementation of the new outpatient PPS under hold harmless provisions.

Explanation of Provision.

The provision would increase Medicare payments for covered outpatient clinic and emergency room visits that are provided by rural hospitals with up to 100 beds on or after January 1, 2004 and before January 1, 2007. Applicable Medicare outpatient fee schedule amounts would be increased up by 5%. The beneficiary copayment amounts for these services would not be affected. The resulting increase in Medicare payments would not be considered as PPS payments when calculating whether a rural hospital's PPS payments are less than its pre-BBA payment amounts under the temporary hold harmless provisions. Also, the budget-neutrality provisions for Medicare's outpatient PPS would not be applicable. Finally, these increased payments would not affect Medicare payments for covered outpatient services after January 1, 2007.

Effective Date

Upon enactment.

Section 416. Increase for Ground Ambulance Services Furnished in a Rural Area.

Current Law

Traditionally, Medicare has paid suppliers of ambulance services on a reasonable charge basis and paid provider-based ambulances on a reasonable cost basis. BBA 1997 provided for the establishment of a national fee schedule which was to be implemented in phases, in an efficient and fair manner. The required fee schedule became effective April 1, 2002 with full implementation by January, 2006. In the transition period, a gradually decreasing portion of the payment is to be based on the prior payment methodology (either reasonable costs or reasonable charges).

The fee schedule payment amount equals the base rate for the level of service plus payment for milage and specified adjustment factors. Additional milage payments are made in rural areas. BIPA increased payment for rural ambulance mileage for distances greater than 17 miles and up to 50 miles for services provided before January 1, 2004. The amount of the increase was at least one-half of the payment per mile established in the fee schedule for the first 17 miles of transport.

Explanation of Provision

The payments for ground ambulance services originating in a rural area or a rural census tract would be increased by 5% for services furnished on or after January 1, 2004 through December 31, 2006. These increased payments would not affect Medicare payments for covered ambulance services in subsequent periods.

Effective Date

Upon enactment.

Section 417. Ensuring Appropriate Coverage of Air Ambulance Services under Ambulance Fee Schedule.

Current Law

Medicare pays for ambulance services under a fee schedule. Seven categories of ground ambulance services, ranging from basic life support to specialty care transport, and two categories of air ambulance services are established. Payment for ambulance services can only be made if other methods of transportation are contraindicated by the patient's medical conditions, but only to the extent provided in regulations.

Explanation of Provision

The regulations governing ambulance services would be required to ensure that air ambulance services be reimbursed if: (1) the air ambulance service is medically necessary based on the health condition of the patient being transported at or immediately prior to the time of the transport service; and (2) the air ambulance service complies with the equipment and crew requirements established by the Secretary. An air ambulance service would be considered medically necessary when requested: (1) by a physician or hospital in accordance with their responsibilities under the Emergency Medical Treatment and Active Labor Act; (2) as a result of a protocol established by a state or regional emergency medical service agency; (3) by a physician, nurse practitioner, physician assistant, registered nurse, or emergency medical responder who reasonably determines or certifies that patient's condition is such that the time involved in land transport significantly increases the patient's medical risks; or (4) by a Federal or State agency to relocate patients following a natural disaster, an act of war, or a terrorist act. Air ambulance services would be defined as a fixed wing or rotary wing air ambulance services.

Effective Date

The provision would apply to services furnished on or after January 1, 2004.

Section 418. Treatment of Certain Clinical Diagnostic Laboratory Tests Furnished By a Sole Community Hospital.

Current Law

Generally, hospitals that provide clinical diagnostic laboratory tests under Part B are reimbursed using a fee schedule. Sole community hospitals (SCHs) that provide some clinical

diagnostic tests 24 hours a day qualify a 2% increase in the amounts established in the outpatient laboratory fee schedule; no beneficiary cost-sharing amounts are imposed.

Explanation of Provision

SCHs that provide clinical diagnostic laboratory tests covered under Part B in 2004 and 2005 would be reimbursed their reasonable costs of furnishing the tests.

Effective Date

Upon enactment.

Section 419. Improvement in Rural Health Clinic Reimbursement Under Medicare.

Current Law

BBA 1997 extended the per visit payment limits that had existed for independent rural health clinics to provider-based rural health clinics (RHC) except for those clinics based in small rural hospitals with fewer than 50 beds. For services rendered from January 1, 2003 through February 28, 2003, the RHC upper payment limit is $66.46, which reflects a 2.6% increase in 2002 payment limit as established by the 2002 Medicare Economic Index (MEI). For services rendered from March 1, 2003 through December 31, 2003, the Medicare RHC upper payment limit is $66.72, which reflects a 3.0% increase in the 2002 payment limit as established by in the 2003 MEI. The 2002 MEI was used as an update for 3 months because the delayed implementation of the 2003 MEI.

Explanation of Provision

The RHC upper payment would be increased to $80.00 for calendar year 2003. The MEI applicable to primary care services would be used to increase the payment limit in subsequent years.

Effective Date

Upon enactment.

Section 420. Elimination of Consolidated Billing for Certain Services Under the Medicare PPS for Skilled Nursing Facility Services.

Current Law

Under Medicare's prospective payment system (PPS), skilled nursing facilities (SNFs) are paid a predetermined amount to cover all services provided in a day, including the costs

associated with room and board, nursing, therapy, and drugs; the daily payment will vary depending upon a patient's therapy, nursing and special care needs as established by one of 44 resource utilization groups (RUGs). Certain services and items provided a SNF resident, such as physicians' services, specified ambulance services, chemotherapy items and services, and certain outpatient services from a Medicare-participating hospital or critical access hospital, are excluded from the SNF-PPS and paid separately under Part B.

Explanation of Provision

Services provided by a rural health clinic (RHCs) and a federally qualified health center (FQHC) after January 1, 2004 would be excluded from SNF-PPS if such services would have been excluded if furnished by an physician or practitioner who was not affiliated with a RHC or FQHC. Outpatient services that are beyond the general scope of SNF comprehensive care plans that are provided by an entity that is 100% owned as a joint venture by two Medicare-participating hospitals or critical access hospitals would be excluded from the SNF-PPS.

Effective Date

The provision would apply to service furnished on or after January 1, 2004.

Section 421. Freeze in Payment for Items of Durable Medical Equipment and Certain Orthotics.

Current Law

Medicare pays for durable medical equipment (DME), using a fee schedule. Under the fee schedule, covered items are classified into six major categories, on one of which is prosthetics and orthotic devices. In general, fee schedule payments are a weighted average of local and regional prices, subject to national limits (both floors and ceilings), that are updated each year by the consumer price index for urban consumers (CPI-U) for the 12-month period ending with June of the previous year.

Explanation of Provision

Medicare would not increase the DME fee schedule amounts in any of the years from 2004 through 2010 and would update the amounts by the CPI-U in each subsequent year. Payments for orthotic devices that have not been custom-fabricated would be similarly affected. Prosthetics, prosthetic devices, and custom-fabricated orthotics would be updated by the percentage change in the CPI-U. The provision would also subject DME companies, starting in 2006, to an accreditation and quality assurance process.

Effective Date

Upon enactment.

Section 422. Application of Coinsurance and Deductible for Clinical Diagnostic Laboratory Tests.

Current Law

Medicare pays laboratories directly for laboratory services provided to ambulatory patients in an outpatient setting. Three main types of laboratories serve these outpatients: independent laboratories, physician office laboratories, and hospital-based laboratories. Clinical lab services are paid on the basis of areawide fee schedules. The fee schedule amounts are periodically updated. Assignment is mandatory. No beneficiary cost-sharing is imposed.

Explanation of Provision

Medicare would pay independent laboratories 100% of the fee schedule amount. Medicare would pay hospital-based and physician office laboratories 80% of the fee schedule amount. Hospital-based and physician office laboratories would be able to charge beneficiaries a 20% coinsurance amount. The Medicare Part B deductible would not apply to clinical diagnostic laboratory tests furnished by independent laboratories. GAO would be required to conduct a study on the feasibility and advisability of applying Medicare's cost-sharing requirements on clinical diagnostic tests furnished by independent laboratories laboratories. The study would examine: (1) the extent to which these laboratories directly bill patients for cost-sharing amounts imposed by other insurers or, alternatively, delegate the billing and collection activity to the physician or entity ordering the test; (2) the cost that would be incurred by the independent laboratory if required to bill Medicare beneficiaries directly, (3) the consequences of eliminating the direct billing requirement for clinical diagnostic laboratory tests; (4) the costs that would be incurred by the ordering physician or entity if required to bill Medicare on behalf of the laboratory that provided the test or bill the Medicare beneficiary for the cost-sharing amounts; and (5) other areas considered appropriate by GAO. The report, including recommendations concerning cost-sharing requirements and direct billing, would be due to Congress within 1 year of enactment.

Effective Date

The provision would apply to tests furnished on or after January 1, 2004.

Section 423. Basing Medicare Payments for Covered Outpatient Drugs on Market Prices.

(a) Medicare Payment Amount.

Current Law

Although Medicare does not currently provide an outpatient prescription drug benefit, coverage of certain outpatient drugs is specifically authorized by statute. Specifically, under Medicare Part B, outpatient prescription drugs and biologicals are covered if they are usually not self-administered and are provided incident to a physician's services. Drugs and biologicals are also covered if they are necessary for the effective use of covered durable medical equipment, including those which must be put directly into the equipment. In addition, Medicare will pay for certain self-administered oral cancer and anti-nausea drugs, erythropoietin (used to treat anemia), immunosuppressive drugs after covered Medicare organ transplants and hemophilia clotting factors. Vaccines for diseases like influenza, pneumonia, and hepatitis B are considered drugs and are covered by Medicare. Payments for covered outpatient drugs are made under Medicare Part B and are based 95% of the average wholesale price (AWP). The term "AWP" is not defined in statute, but generally, the AWP is intended to represent the average price used by wholesalers to sell drugs to their customers. It has been based on reported prices as published in industry reference publications or drug price compendia. There are no uniform criteria for reporting these numbers. Moreover, these reported prices do not reflect the discounts that manufacturers and wholesalers customarily offer to providers and physicians. To differing degrees, the published prices on which Medicare payment's are based are higher than the amounts actually paid to acquire a given prescription drug.

Because the covered outpatient prescription drugs are Part B services, Medicare pays 80% of the recognized amount and the beneficiary is liable for the remaining 20% coinsurance amount, except in the case of vaccines where no beneficiary cost-sharing is imposed. Also, beneficiaries cannot be charged for any amounts in excess of the recognized payment amount.

Explanation of Provision

Drugs or biologicals furnished before January 1, 2004 would be paid at 95% of the AWP. After January 1, 2004 until December 31, 2003, existing drugs and biologicals would be paid the lower of the AWP or 85% of the listed AWP as of April 1, 2003. In subsequent years, this price would increased by change the consumer price index (CPI) for medical care for the previous year ending in June. Existing drugs and biologicals are those first available for payment on or before April 1, 2003. After January 1, 2004, payments for influenza virus, pneumococcal pneumonia, and hepatitis B vaccines would be equal to the AWP.

The Secretary would be required to establish a process to determine whether the widely available market price to physicians and suppliers for drugs and biologicals furnished in a year is different from the AWP amounts. This determination would be based on (1) any report on market price published by the Inspector General (IG) of the Department of Health and Human Services (HHS) or GAO after December 31,1999; a review of market prices by the Secretary including information from insurers, private health plans, manufacturers, wholesalers, distributors, physician supply houses, specialty pharmacies, group purchasing arrangements,

physicians, suppliers or any other appropriate source as determined by the Secretary; (3) data submitted by the manufacturer of the drug or biological or by another entity; and (4) other appropriate information as determined by the Secretary. If the market price for a drug or biological determined through this process differs from the AWP amount, that market price shall be treated as the AWP amount when determining Medicare's payment for a drug or biological in 2004 and subsequently. The Secretary would be able to make subsequent determinations with respect to the widely available market price for a given drug or biological. If not, the prior market price determination will be considered as the basis for Medicare's payment amount for such an item.

If, however, the first market price determination for a given drug or biological would result in a payment amount that is 15% less than would otherwise be made, the Secretary would provide for an appropriate transition period where the price is reduced in annual increments equal to 15% of Medicare's payment amount in the previous year. At the end of the transition period, the market price (as determined) would serve as basis for Medicare's payment amount. This transition period would not apply to a drug or biological where a generic version of that drug or biological first enters the market on or after January 1, 2004. The generic version would not be required to be marketed under the chemical name of the given drug or biological.

New drugs and biologicals, those that are first available for Medicare payment after April 1, 2003, would be subject to certain requirements in order to obtain a code and receive Medicare payment. A manufacturer would be required to provide the Secretary with necessary and appropriate information on the estimated price that the manufacturer expects physicians and suppliers to pay to routinely obtain the drug or biological; the manufacturer would be able to provide the Secretary with other appropriate information as well. During the first year that the drug or biological is available for Medicare payment, the manufacturer would be required to provide the Secretary with updated information on the actual market prices paid by physicians or suppliers for such drugs and biologicals. These market prices would be equal to the lesser of the average wholesale price for the drug or biological or the amount determined by the Secretary based on information originally submitted by the manufacturer supplemented by other appropriate information. The market price of the drug or biological during the second year after becoming available for Medicare payment is subject to the same conditions as in the first year. In subsequent years, the market price would be equal to the lesser of the average wholesale price or the widely available market price as determined by the Secretary in the same fashion as for existing drugs. If no market price determination occurs, then Medicare's payment for drug or biological in the prior year is updated by the change in the CPI for medical care for the previous year ending in June.

Effective Date

Upon enactment.

(b) Adjustments to Payment Amounts for Administration of Drugs and Biologicals.

This subsection contains the following provisions:

Adjustments in the Physician Practice Expense Relative Values.

Current Law

The relative value associated with a particular physician services is the sum of three components: physician work, practice expense, and malpractice expense. Practice expense include both direct costs (such as clinical personnel time and medical supplies used to provide a specific service to an individual patient) as indirect costs such as rent, utilities, and business costs associated with running a practice). When the physician fee schedule was implemented, reimbursement for practice expenses was based on historic charges. The Social Security Act Amendments of 1994 (PL. 103-432) required the Secretary to develop a methodology for a resource based system for calculating practice expenses for use in CY1998. BBA 1997 delayed the implementation of the methodology until CY1999 and established a transition period with full implementation by CY2002. BBRA required the Secretary to establish a data collection process and data standards for determining practice expense relative values. Under this survey process, the Secretary was required to use data collected or developed outside HHS, to the maximum extent practicable, consistent with sound data collection practices.

The Secretary is required to periodically review and adjust the relative values affecting physician payment to account for changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. Under the budget-neutrality requirement, changes in these factors cannot cause expenditures to differ by more than $20 million from what would have been spent if such adjustments had not been made.

Explanation of Provision

The Secretary would be required to establish the practice expense relative value for the physician fee schedule in CY2004 using the survey data collected from a physician specialty organization if the data covers the practice expenses for oncology administration services and meets the Secretary's criteria for acceptable survey data. The Secretary would also be required to review and appropriately modify Medicare's payment policy for the administration of more than one anticancer chemotherapy agents to an individual patient on a single day. The increase in expenditures resulting from this provision would be exempt from the budget-neutrality requirement. Also, the Secretary would be required to adjust the nonphysician work pool methodology so that practice expense relative values for these services are not disproportionately reduced as a result of the above changes.

Effective Date

Upon enactment.

Administration of Blood Clotting Factors.

Current Law

Medicare will pay for blood clotting factors for hemophilia patients who are competent to use such factors to control bleeding without medical supervision as well as the items related to the administration of such factors.

Explanation of Provision

The Secretary would be required to review a GAO report, *Payment for Blood Clotting Factors Exceeds Providers Acquisition Costs'* (GAO-03-184) and provide a separate payment for the administration of these factors. The total amount of payments for blood clotting factors furnished in CY2004 would not exceed the amount that would have otherwise been expended. In CY2005 and subsequently, this separate payment amount would be updated by the change in the CPI for medical care for the previous year ending in June.

Effective Date

Upon enactment.

Increase in the Composite Rate for End Stage Renal Disease Facilities.

Current Law

As discussed in Section 413 of this legislation, dialysis facilities providing care to beneficiaries with end-stage renal disease (ESRD) receive a fixed prospectively determined payment amount (the composite rate) for each dialysis treatment, regardless of whether services are provided at the facility or in the patient's home. Medicare pays separately for erythropoietin (EPO) which is used to treat anemia for persons with chronic renal failure who are on dialysis. Congress has set Medicare's payment for EPO at $10 per 1,000 units whether it is administered intravenously or subcutaneously in dialysis facilities or in patients' homes. Providers receive 95% of the AWP for separately billable injectable medications other than EPO administered during treatments at the facility.

Explanation of Provision

The composite rate for dialysis services furnished during 2004 would be increased as specified in earlier and then further increased. These composite rates would be increased so that

facility payments would equal the composite rate payments (as increased by this an earlier provision in the legislation) plus payments made for separately billed drugs and biologicals (not including EPO) as if this drug pricing provisions of this legislation were not enacted. During 2005, the ESRD composite rate would be increased by 0.20 percentage points During 2006 and subsequently, the ESRD composite rate of the previous year (calculated without the temporary increase specified earlier in this legislation) would be increased by 0.20 percentage points. These payment amounts, methods or adjustments would not be subject to administrative or judicial review under the statutory appeals processes in established by Section 1869 of the Social Security Act (SSA), by the Provider Reimbursement Review Board established by Section 1878 of the SSA, or otherwise.

Effective Date

Upon enactment.

Home Infusion and Inhalation Drugs

Current Law

Medicare will cover outpatient prescription drugs and biologicals if they are necessary for the effective use of covered durable medical equipment (DME), including those drugs which must be put directly into the equipment such as tumor chemotherapy agents used with infusion pump (home infusion drugs) or respiratory drugs given through a nebulizer (inhalation drugs).

Explanation of Provision

The Secretary would be able to make separate payments for infusion drugs and biologicals furnished through covered DME on or after January 1, 2004, if such payments are determined to be appropriate. Total amount of payments for the infusion drugs in the year could not exceed the total amount of spending that would have occurred without enactment of this legislation.

The Secretary would be able to increase payments for covered DME associated with inhalation drugs and biologicals and make separate payments for such drugs and biologicals furnished through covered DME on or after January 1, 2004, if such payments are determined to be appropriate. The associated spending attributed to the increased and separate payments for the covered DME and inhalation drugs and biologicals in the year would not exceed the 10% of the difference between the savings in total spending for these drug and biologicals attributed to the prescription drug pricing changes enacted in this legislation.

Effective Date

Upon enactment.

Pharmacy Dispensing Fee for Certain Drugs and Biologicals

Current Law

Medicare pays for certain outpatient prescription drugs and biologicals. For instance, Medicare pays a dispensing fee in conjunction with inhalation therapy drugs used in nebulizers. Medicare does not pay a dispensing fee to pharmacists or providers who supply oral drugs.

Explanation of Provision

Medicare would pay a dispensing fee (less the applicable deductible and coinsurance amounts) to licensed approved pharmacies for covered immunosuppressive drugs, oral anti-cancer drugs, and oral anti nausea drugs used as part of an anti-cancer chemotherapeutic regimen. Medicare would be able to pay a dispensing fee (less the applicable deductible and coinsurance amounts) to licensed approved pharmacies for other drugs and biologicals.

Effective Date

Upon enactment.

(c) Prohibition Of Administrative and Judicial Review.

Current Law

Medicare beneficiaries and, in certain circumstances, providers and suppliers of health care services may appeal adverse determinations regarding claims for benefits under Part A and Part B. Section 1869 of the SSA allows these parties who have been denied coverage of an item or service the right to appeal that decision through a series of administrative appeals and then into federal district court under certain circumstances. Section 1878 of the SSA allows providers who are dissatisfied with certain cost reporting determinations that affect their reimbursement amounts the right to appeal that decision in front of the Provider Reimbursement Review Board and then into federal district court if the certain thresholds regarding the amount in dispute are met at each step of the appeals process.

Explanation of Provision

The provisions concerning Medicare's determination of payment amounts for existing and new drugs and biologicals including the administration of blood clotting factors, home infusion drugs and inhalation drugs would not be subject to administrative or judicial review under Sections 1869 and 1878 of the SSA or otherwise.

The provisions affecting the adjustments affecting the practice expense relative values, multiple chemotherapy agents administered on a single day, and treatment of other services

currently in the nonphysician workpool would not be subject to administrative or judicial review under Sections 1869 and 1878 of the SSA or otherwise.

Effective Date

Upon enactment.

(d) Studies and Reports.

Current Law

No provision

Explanation of Provision

GAO would be required to conduct a study that examines the impact of the drug payment and adjustment provisions on the access of Medicare beneficiaries' to covered drugs and biologicals. The report, including appropriate recommendations, would be due to Congress no later than January 1, 2006. The HHS IG would be required to conduct one or more studies that examine the market prices for Medicare covered drugs and biologicals which are widely available to physicians and suppliers. The report would examine report would examine those drugs and biologicals that represent the largest portion of Medicare spending on such items and include a comparison of market prices with Medicare payment amounts.

Effective Date

Upon enactment.

Section 424. Revisions to Reassignment Provisions.

Current Law

Generally, beneficiaries are the parties who are entitled to receive Medicare payments under the Medicare statute. However, beneficiaries can assign these rights to participating physicians, suppliers, and other providers who directly provide the care and then submit claims for Medicare payment. Medicare also permits physicians to reassign their right to payment to certain other entities, such as the hospitals or other facilities where services are performed, or to their employers. Physicians cannot reassign their right to payment to staffing companies (entities that retain physicians on a contractual basis).

Explanation of Provision

Staffing companies (individuals or entities) would be able to submit claims to Medicare for physician services provided under contractual arrangement between the company and the physician, if the arrangement meets appropriate program integrity and other safeguards established by the Secretary.

Effective Date

The provisions would apply to payments made on or after the date of enactment.

Section 425. Extension of Treatment for Certain Physician Pathology Services Under Medicare.

Current Law

In general, independent laboratories cannot directly bill for the technical component of pathology services provided to Medicare beneficiaries who are inpatients or outpatients of acute care hospitals. BIPA permitted independent laboratories with existing arrangements with acute hospitals to bill Medicare separately for the technical component of pathology services provided to the hospitals' inpatients and outpatients. The arrangement between the hospital and the independent laboratory had to be in effect as of July 22, 1999. The direct payments for these services apply to services furnished during a 2-year period starting on January 1, 2001 and ending December 31, 2002.

Explanation of Provision

Direct payments for the technical component for these pathology services would be extended two additional years for services furnished until December 31, 2004.

Effective Date

Upon enactment.

Section 426. Demonstration of Coverage of Chiropractic Services under Medicare.

Current Law

No specific provision with respect to a demonstration project. Medicare covers limited chiropractic services, specifically manual manipulation for correction of a dislocated or misaligned vertebra or subluxation.

Explanation of Provision

Within 1 year of enactment, the Secretary would be required to establish a 3-year demonstration program at 6 sites to evaluate the feasibility and desirability of covering additional chiropractic services under the Medicare program. The chiropractic services included in the demonstration shall include, at a minimum, care for neuromusculoskeletal conditions typical among eligible beneficiaries as well as diagnostic and other services that a chiropractor is legally authorized to perform. An eligible beneficiary participating in the demonstration project including those enrolled in Medicare +Choice or MedicareAdvantage plans would not be required to receive approval by physician or other practitioner in order to receive chiropractic services under the demonstration project. The Secretary would be required to consult with chiropractors, organizations representing chiropractors, beneficiaries and organizations representing beneficiaries in establishing the demonstration projects. Participation by eligible beneficiaries would be on a voluntary basis. The 6 sites would be equally split between rural and urban areas; at least one of the sites would be in a health professional shortage area. The Secretary would be required to evaluate the demonstration projects to determine (1) whether the participating beneficiaries used fewer Medicare covered services than those who did not participate; (2) the cost of providing such chiropractic services under Medicare; (3) the quality of care and satisfaction of participating beneficiaries; and (4) other appropriate matters. The Secretary would be required to submit a report, including recommendations, to Congress on the evaluation no later than 1 year after the demonstration projects conclude. The Secretary would waive Medicare requirements as necessary. The demonstration program would be subject to a budget-neutrality requirement. Appropriations from the Federal Supplementary Insurance Trust Fund are authorized as necessary to conduct this demonstration.

Effective Date

Upon enactment.

Section 427. Medicare Health Care Quality Improvement Demonstration Programs.

Current Law

No provision.

Explanation of Provision

The Secretary would be required to establish a 5-year demonstration program that examines the health delivery factors which encourage the delivery of improved patient care quality including: (1) the provision of incentives to improve the safety of care provided to beneficiaries; (2) the appropriate use of best practice guidelines; (3) the reduction of scientific uncertainty through examination of service variation and outcomes measurement; (4) the encouragement of shared decision making between providers and patients; (5) the provision of incentives to improve care, safety, and efficiency; (6) the appropriate use of culturally and ethnically sensitive care; and (7) the related financial effects associated with these changes. The

participants would include appropriate health care groups including physician groups, integrated health care delivery systems, or regional coalitions. The demonstration projects may incorporate approved alternative payments, include modification to the traditional fee-for-service benefit package, and would be subject to budget-neutrality restriction. The Secretary would be able to waive Medicare and Medicaid requirements as necessary and may direct agencies within Health and Human Services (HHS) to evaluate, analyze, support, and assist in the demonstration project. The demonstration program would be subject to a budget-neutrality requirement.

Effective Date

Upon enactment.

Section 428. GAO Study of Geographic Differences in Payments for Physicians' Services.

Current Law

No provision.

Explanation of Provision

GAO would be required to study geographic differences in payment amounts in the physician fee schedule including: (1) an assessment of the validity of each component of the geographic adjustment factors; (2) an evaluation of the measures and the frequency with which they are revised; (3) an evaluation of the methods used to establish the costs of professional liability insurance including the variation between physician specialities and among different states, the update to the geographic cost of practice index, and the relative weighs for the malpractice component; (4) an evaluation of the economic basis for the floors on the geographic adjustments established previously in this legislation; and (5) an evaluation of the effect of the geographic adjustments on physician retention, recruitment costs, physician mobility as well as the appropriateness of extending such adjustment. The study should include a comparative analysis regarding the cost of physician recruitment and retention in rural areas versus urban areas, and make recommendations concerning use of more current data and use of cost data rather than price proxies. The study would be due to Congress within 1 year of enactment.

Effective Date

Upon enactment.

Subtitle C – Provisions Relating to Parts A and B

Section 441. Increase for Home Health Services Furnished in a Rural Area.

Current Law

The Medicare home health PPS which was implemented on October 1, 2000 provides a standardized payment for a 60-day episode of care furnished to a Medicare beneficiary. Medicare's payment is adjusted to reflect the type and intensity of care furnished and area wages as measured by the hospital wage index. BIPA increased PPS payments by 10% for home health services furnished in the home of beneficiaries living in rural areas during the 2-year period beginning April 1, 2001, through March 31, 2003, without regard to certain budget-neutrality provisions applying to home health PPS. The temporary additional payment is not included in the base for determination of payment updates.

Explanation of Provision

The provision would extend a 5% additional payment for home health care services furnished in a rural area on or after October 1, 2003 and before October 1, 2005 without regard to certain budget-neutrality requirements. The temporary additional payment would not be considered when determining future home health payment amounts.

Effective Date

Upon enactment.

TITLE V- REGULATORY RELIEF

Subtitle A - Regulatory Reform

SECTION 501. RULES FOR THE PUBLICATION OF A FINAL REGULATION BASED ON THE PREVIOUS PUBLICATION ON AN INTERIM FINAL REGULATION

Current Law

The Secretary is required to prescribe regulations that are necessary to administer the Medicare program. The Secretary must publish proposed regulations in the Federal Register, with at least 30 days to solicit public comment before issuing the final regulation except in the following circumstances: (1) the statute permits the regulation to be issued in interim final form or provides for a shorter public comment period; (2) the statutory deadline for implementing a

provision is less than 150 days after the date of enactment of the statute containing the provision; (3) under the good cause exception contained in the rule-making provision of title 5 of the United States Code, notice and public comment procedures are deemed impracticable, unnecessary or contrary to the public interest.

Explanation of Provision

The Secretary would be required to publish a final regulation within 12 months of the publication of an interim final regulation or the interim final regulation would no longer be effective. Subject to appropriate notice, the Secretary would be able to extend this deadline for up to 12 additional months. The Secretary would be required to publish a notice in the *Federal Register* 6 months after the date of enactment providing the status of each interim final regulation for which no final regulation has been published and providing the date by which the final regulation is planned to be published.

Effective Date

The requirement for publishing the final regulation following the interim final regulation would be effective on the date of enactment and would apply to interim final regulations published on or after the date of enactment.

SECTION 502. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES

Current Law

No explicit statutory instruction. As a result of case law, there is a strong presumption against retroactive rulemaking. In *Bowen v. Georgetown University Hospital*, the Supreme Court ruled that there must be explicit statutory authority to engage in retroactive rulemaking.

Explanation of Provision

The provision would bar retroactive application of any substantive changes in regulation, manual instructions, interpretative rules, statements of policy, or guidelines unless the Secretary determines retroactive application is needed to comply with the statute or is in the public interest. No substantive change would take effect until 30 days after the change is issued or published unless the change is needed to comply with statutory changes or is in the public interest. Compliance actions could be taken for items and services furnished only on or after the effective date of the change.

Effective Date

The prohibition of retroactive application of substantive changes would apply to changes issued on or after the date of enactment. The provisions affecting compliance with substantive

changes would apply to compliance actions undertaken on or after the date of enactment.

SECTION 502. REPORT ON LEGAL AND REGULATORY INCONSISTENCIES

Current Law

No provision.

Explanation of Provision

Requires the Secretary to report to Congress in two years, and every three years thereafter, on the administration of Medicare and areas of inconsistency or conflict among various provisions under law and regulation and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.

Effective Date

Upon enactment.

SUBTITLE B – APPEALS PROCESS REFORM

SECTION 511. SUBMISSION OF PLAN FOR TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS

Current Law

Denials of claims for Medicare payment may be appealed by beneficiaries (or providers who are representing the beneficiary) or in certain circumstances, providers or suppliers directly. The third level of appeal is to an administrative law judge (ALJ). The ALJs that hear Medicare cases are employed by the Social Security Administration – a legacy from the inception of the Medicare program when Medicare was part of Social Security.

Explanation of Provision

The Secretary and Commissioner of Social Security would be required to develop and transmit to Congress a plan for transferring the functions of administrative law judges (ALJs) responsible for hearing cases under Medicare from the Social Security Administration to HHS no later than April 1, 2004. The plan would be required to include information on: workload; cost projections and financing; transition timetable; regulations; development of a case tracking system; feasibility of precedential authority; feasibility of electronic appeals filings and teleconference; steps needed to assure independence of ALJs, including assuring that they are in an office that is operationally and functionally separate from the Centers for Medicare and

Medicaid Services and the Center for Medicare Choices; geographic distribution of ALJs; hiring of ALJs; performance standards of ALJs; sharing resources with Social Security regarding ALJs; training; and recommendations for further Congressional action. The GAO would be required to evaluate the Secretary's and Commissioner's plan and report to Congress on the result of the evaluation within 6 months of the receiving the plan. The Secretary would be prohibited from implementing the plan developed until no earlier than 6 month after the GAO report.

Effective Date

Upon enactment.

SECTION 512. EXPEDITED ACCESS TO JUDICIAL REVIEW

Current Law

In general, administrative appeals must be exhausted prior to judicial review.

Explanation of Provision

The Secretary would be required to establish a process where a provider, supplier, or a beneficiary may obtain access to judicial review when a review entity (a panel of no more than three members from the Departmental Appeals Board) determines, within 60 days of a complete written request, that it does not have the authority to decide the question of law or regulation and where material facts are not in dispute. The decision would not be subject to review by the Secretary. Interest is assessed on any amount in controversy and is awarded by the reviewing court in favor of the prevailing party. This expedited access to judicial review would be permitted for cases where the Secretary does not enter into or renew provider agreements.

The Comptroller General would be required to report to Congress on the access of Medicare beneficiaries and health care providers to judicial review of actions of the Secretary and HHS after February 29, 2000 (the date of the decision of *Shalala v. Illinois Council on Long Term Care, Inc.* (529 U.S. 1 (2000)). The report would be due not later than one year after enactment.

Effective Date

The provision would be effective for appeals filed on or after October 1, 2004.

SECTION 513. EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS

Current Law

The statute prohibits approval of nurse aide training programs in skilled nursing facilities that have been subject to extended survey (that is, found to provide substandard care), have had serious sanctions imposed, or have waivers for required licensed nurse staffing.

Explanation of Provision

The Secretary would be required to develop and implement a process to expedite review for certain remedies imposed against skilled nursing facilities (SNFs) including termination of participation, immediate denial of payments, immediate imposition of temporary management, and suspension of nurse aide training programs.

This provision would authorize the appropriation of such sums as needed for FY2004 and subsequent years to reduce by 50% the average time for administrative determinations, to increase the number of ALJs and appellate staff at the DAB, and to educate these judges and their staffs on long-term care issues.

Effective Date

Upon enactment.

SECTION 514. REVISIONS TO MEDICARE APPEALS PROCESS

Current Law

The overall appeals process is established in the statute. The Benefits Improvement and Protection Act (BIPA) of 2000 changed the appeals process and created a new independent review (the qualified independent contractors or QICs). BIPA established timeframes for each of the four levels of appeals as follows: 30 days at the contractor redetermination level, 30 days at the QIC reconsideration level, 90 days at the administrative judge level, and 90 days at the Departmental Appeals Board level. BIPA called for the establishment of at least 12 QICs. The BIPA claims appeals provisions were effective October 1, 2002.

Explanation of Provision

Subsection (a) would establish a 90-day timeframe for completing the record in a hearing before an administrative law judge (ALJ) or the HHS Departmental Appeals Board (DAB), but provides extensions for good cause. Subsection (b) would provide for the use of beneficiaries' medical records in qualified independent contractors reconsiderations. Subsection (c) would

require that notice of and decisions from determinations, redeterminations, reconsiderations, ALJ appeals, and DAB appeals be written in a manner understandable to a beneficiary and that includes, as appropriate, reasons for the determination or decision and the process for further appeal. Subsection (d) would clarify eligibility requirements for qualified independent contractors and their reviewer employees including medical and legal expertise, independence requirements, and prohibitions on compensation being linked to decisions rendered. The required number of qualified independent contractors would be reduced from 12 to four. Subsection (e) would delay the effective date of certain appeals provisions until December 1, 2004. Expedited determinations would be delayed until October 1, 2003. The provision would allow the transitional use of peer review organizations (now called quality improvement organizations by the Secretary) to conduct expedited determinations until the QICs are operating.

Effective Date

The provisions of this section would be effective as if they were enacted in BIPA.

SECTION 515. HEARING RIGHTS RELATED TO DECISIONS BY THE SECRETARY TO DENY OR NOT RENEW A MEDICARE ENROLLMENT AGREEMENT; CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS

Current Law

Under administrative authorities, CMS has established provider enrollment processes in instructions to the contractors. A provider denied a provider agreement is entitled to in a hearing by the Secretary.

Explanation of Provision

The Secretary would be required to develop a process for providers and suppliers to appeal denials or non-renewals of provider agreements. The Secretary would be required to consult with providers and suppliers before changing the provider enrollment forms.

Effective Date

The process for appealing denials or non-renewals of provider agreements would be required within 18 months after enactment. The requirement for consultation before changing the enrollment forms would be effective upon enactment.

SECTION 516. APPEALS BY PROVIDERS WHEN THERE IS NO OTHER PARTY AVAILABLE

Current Law

No provision.

Explanation of Provision

In the case where a beneficiary dies before assigning appeal rights, the Secretary would be required to permit a provider or supplier to appeal a payment denial by a Medicare contractor.

Effective Date

The provision would be effective for items and services furnished on or after enactment.

SECTION 517. PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS

Current Law

Only beneficiaries have standing to appeal local coverage decisions by Medicare contractors.

Explanation of Provision

The parties that have standing to appeal local coverage decisions would be expanded to include providers or suppliers adversely affected by the determination. The Secretary would be required to establish a process whereby a provider or supplier may request a local coverage determination under certain circumstances. A provider or supplier could seek a local coverage determination if the Secretary determined that: (A) there have been at least five reversals by an ALJ of redeterminations made by a medicare contractor in at least two different cases; (B) that each reversal involved substantially similar material facts; (C) each reversal involved the same medical necessity issue; and (D) at least 50% of the total claims submitted by the provider within the past year involving the requisite facts and medical necessity issue have been denied and then reversed by an ALJ. Such sums as necessary to carry out the provisions above would be authorized to be appropriated. Also the provision would require the Secretary to study and report to Congress on the feasibility and advisability of requiring Medicare contractors to track the subject and status of claims denials that are appealed and final determinations.

Effective Date

The expansion in standing would be effective for any review or request of any local coverage determination filed on or after October 1, 2003 and for any local coverage determination made on or after October 1, 2003. The requirement to establish a process for a provider or supplier to request a local coverage determination would be effective for requests

filed on or after the date of enactment. The report would be due to Congress not later than one year after the date of enactment.

SUBTITLE C – CONTRACTING REFORM

SECTION 521. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION

Current Law

The Secretary is required to contract with health insurance companies to process and pay Medicare Part B claims and may accept the nomination of hospitals for entities to process and pay their Medicare claims.

Certain terms and conditions of the contracting agreements for fiscal intermediaries (FIs) and carriers are specified in the Medicare statute. Medicare regulations coupled with long-standing agency practices have further limited the way that contracts for claims administration services can be established.

Explanation of Provision

This provision would add Section 1874A to the Social Security Act and would permit the Secretary to competitively contract with any eligible entity to serve as a Medicare contractor (Medicare Administrative Contractors (MACs)) and eliminates the distinction between Part A contractors and Part B contractors. The Secretary would be permitted to renew the MAC contracts annually for up to 6 years. All contracts would be required to be recompeted at least every 6 years. Federal Acquisition Regulations (FAR) would apply to these contracts except to the extent any provisions are inconsistent with a specific Medicare requirement, including incentive contracts. Competitive bidding for the MACs would be required to begin for annual contract periods that begin on or after October 1, 2011.

The provision would limit liability for improper Medicare payments for certifying and disbursing officers and the Medicare Administrative Contractors except where the person or entity acted with reckless disregard or the intent to defraud the United States. This limitation on liability would not limit liability for conduct that would violate the False Claims Act. The provision also establishes circumstances where contractors and their employees could be indemnifiedby the Secretary.

The provision would require that MACs developing local coverage determinations should designate at least one different individual to serve as medical director for every 2 states for which such MAC is responsible for developing local coverage determinations.

Effective Date

Upon enactment, except the provision relating to local coverage determinations shall take effect on October 1, 2005.

SUBTITLE D – EDUCATION AND OUTREACH IMPROVEMENTS

SECTION 531. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

Current Law

Medicare's provider education activities are funded through the program management appropriation and through Education and Training component of the Medicare Integrity Program (MIP). The statute requires toll-free lines that beneficiaries can call with questions or to report suspicious bills. Under administrative authority, CMS requires the contractors to have internet sites and to respond to written inquiries.

Explanation of Provision

Subsection (a) would require the Secretary to coordinate the educational activities through the Medicare contractors to maximize the effectiveness of education efforts for providers and suppliers. Subsection (b) would require the Secretary to use specific claims payment error rates (or similar methodology) to provide incentives for contractors to implement effective education and outreach programs for providers and suppliers. It would require the Comptroller General to study the adequacy of the methodology and make recommendations to the Secretary, and the Secretary would be required to report to Congress regarding how he intends to used the methodology in assessing Medicare contractor performance. Subsection (c) would provide increased funding for the Medicare Integrity Program of $35 million beginning with FY2004 for increased provider and supplier education. Also would require Medicare contractors to take into consideration the special needs of small providers or suppliers when conducting education and training activities and permits provision of technical assistance beginning January 1, 2004. Subsection (d) would bar Medicare contractors from using a record of attendance (or non-attendance) at educational activities to select or track providers or suppliers in conducting any type of audit or prepayment review.

Effective Date

Upon enactment.

SECTION 532. ACCESS TO AND PROMPT RESPONSES FROM MEDICARE CONTRACTORS.

Current Law

No specific statutory provision. The Medicare statute generally requires that the Medicare contractors communicate information about Medicare administration.

Explanation of Provision

This provision would require the Secretary to develop a process for Medicare contractors to communicate with beneficiaries, providers, and suppliers. Also, the provision would require Medicare contractors to provide a clear, concise written response to inquiries within 45 business days. The Secretary would be required to ensure that Medicare contractors provide a toll-free number where beneficiaries, providers and suppliers can obtain billing, coding, claims, coverage and other information. The Medicare contractors would be required to maintain a system for identifying the staff person who provided information and monitoring the accuracy, consistency and timeliness of information provided. The provision would require the Secretary to establish standards regarding accuracy, consistency, and timeliness and to evaluate the Medicare contractors on these standards. The provision would authorize to be appropriated such sums as necessary to carry out the provision.

Effective Date

The provision would be effective October 1, 2004.

SECTION 533. RELIANCE ON GUIDANCE

Current Law

No provision.

Explanation of Provision

If a provider or supplier reasonably relies on written guidance provided by the Secretary or a Medicare contractor when furnishing items or services or submitting a claim and the guidance is inaccurate, under this provision the provider or supplier would not be required to pay any penalty or interest relating to items or services provided or claim submitted.

Effective Date

The provision would be effective for penalties imposed on or after the date of enactment.

SECTION 534. MEDICARE PROVIDER OMBUDSMAN

Current Law

No provision.

Explanation of Provision

This provision would direct the Secretary to create a Medicare Provider Ombudsman within the Department of Health and Human Services and provide appropriate staff. The Provider Ombudsman would provide confidential assistance to entities and individuals providing items and services, including covered drugs under part D, that are covered under Medicare. The Ombudsman would also submit recommendations to the Secretary for improving the administration of Medicare, recommendations regarding recurring patterns of confusion under Medicare and recommendations to provide for an appropriate and consistent response in cases of self-identified overpayments by providers and suppliers. Such sums as necessary would be authorized to be appropriated for FY2004 and subsequent years.

Effective Date

The Secretary would be required to appoint the Provider Ombudsman not later than one year from the date of enactment.

SECTION 535. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM

Current Law

No provision.

Explanation of Provision

Subsection (a) would require the Secretary to conduct a three-year demonstration program where Medicare specialists would provide assistance to beneficiaries in at least six local Social Security offices (two would be located in rural areas) that have a high volume of visits by Medicare beneficiaries. The Secretary would be required to evaluate the results of the demonstration regarding the feasibility and cost-effectiveness of permanently out-stationing Medicare specialists at local Social Security offices and report to Congress.

Subsection (b) would require that the Secretary establish a demonstration project to test the administrative feasibility of providing a process for Medicare beneficiaries, providers, suppliers and other individuals or entities furnishing items or services under Medicare, where an advance beneficiary notice is issued, to request and receive a determination as to whether the item or service is covered under Medicare by reasons of medical necessity, before the item or

suppliers could correct minor errors in claims that were submitted for payment.

Effective Date

The proposal would require that the process be developed not later than one year after enactment.

SECTION 544. AUTHORITY TO WAIVE A PROGRAM EXCLUSION

Current Law

The Secretary has the authority to waive exclusion from participation in any Federal health program when the provider is the sole source of care in a community, at the request of a state.

Explanation of Provision

The Secretary would be permitted to waive a program exclusion at the request of an administrator of a federal health care program (which includes state health care programs), after consulting with the Inspector General of HHS.

Effective Date

Upon enactment.

TITLE VI- OTHER PROVISIONS

Subtitle C–Other Provisions

Section 601. Continuation of BIPA Rule for Determination of Medicaid DSH Allotments for Fiscal Year 2004

Current Law

Hospitals that serve a large number of uninsured patients and Medicaid enrollees receive additional Medicaid disproportionate share hospital (DSH) payments. As established in the BBA 1997, the federal share of Medicaid DSH payments is capped at specified amounts for each state for FY1998 through FY2002. For most states, those specified amounts declined over the 5-year period. A state's allotment for FY2003 and for later years is equal to its allotment for the previous year increased by the percentage change in the consumer price index for urban consumers (CPI-U) for the previous year. In addition, each state's DSH payment for FY 2003 and subsequent years is limited to no more than 12% of spending for medical assistance in each state for that year.

BIPA provided states with a temporary reprieve from the declining allotments by

establishing a special rule for the calculation of DSH allotments for 2 years, raising allotments for FY2001 and for FY2002. The provision also clarified that the FY2003 allotments were to be calculated as specified above, using the lower, pre-BIPA levels for FY2002 in those calculations.

Explanation of Provision

The special DSH rule established by BIPA that raised DSH allotments, subject to the current law limit of 12% of spending for medical assistance, would be extended for FY2004. Allotments for FY2004 would be calculated to be equal to FY2002 allotments as under BIPA increased by the percentage change in the CPI-U for each of FYs 2002 and 2003. Allotments for FY2005 would be equal to FY2002 allotments (as established by BBA 1997 and subject to the current law limit of 12% of spending for medical assistance) increased by the percentage change in the CPI-U for each of FY2002, FY2003, and FY2004. For FY2006 and thereafter, DSH allotments would be calculated based on the previous years' amount (subject to the current law limit of 12% of spending for medical assistance) increased by the percentage change in the CPI-U for the previous year.

A separate calculation of the DSH allotment for the District of Columbia for FY2004 would be specified. The DSH allotment for the District of Columbia for FY2004 would be raised, subject to the current law limit of 12% of spending for medical assistance, by multiplying $49 million by the percentage change in the CPI-U for each of FY2000, FY2001, FY2002, and FY2003.

Effective Date

Upon enactment.

SEC. 602. Increase in the Floor for Treatment as an Extremely Low DSH State Under the Medicaid Program for Fiscal Years 2004 and 2005.

Current Law

Extremely low DSH states are those states whose FY1999 federal and state DSH expenditures (as reported to CMS on August 31, 2000) are greater than zero but less than 1% of the state's total medical assistance expenditures during that fiscal year. DSH allotments for the extremely low DSH states for FY2001 would be equal to 1% of the state's total amount of expenditures under their plan for such assistance during that fiscal year. For subsequent fiscal years, the allotments for extremely low DSH states would be equal to their allotment for the previous year, increased by the percentage change in the CPI-U for the previous year, subject to a ceiling of 12% of that state's total medical assistance payments in that year.

Explanation of Provision

Allotments for certain extremely low DSH states for FY2004 and FY2005 would be increased. For states with DSH expenditures for FY2002 (as reported to CMS as of August 31, 2003) that are greater than zero but less than 3% of the state's total medical assistance expenditures during that fiscal year, the provision would raise the DSH allotments for FY2004 to 3% of the state's total amount of expenditures for such assistance during that fiscal year. States with DSH expenditures for FY2003 (as reported to CMS as of August 31, 2004) that are greater than zero but less than 3% of the state's total medical assistance expenditures during that fiscal year would have the DSH allotments for FY2005 be calculated by taking the FY2004 allotment and increasing by the percentage change in the CPI-U for the previous fiscal year.

A special DSH allotment adjustment for FY2004 and FY2005 is made for states whose Section 1115 waivers were implemented on January 1, 1994. If such state-wide Section 1115 waiver is revoked or terminated during FY2004 and/or FY2005, the Secretary of HHS would permit a state to submit an amendment to its state plan that would describe the methodology to be used by the State to identify and make payments for disproportionate share hospitals (including children's hospitals, and institutions for mental diseases, or other mental health facilities–other than State-owned institutions or facilities), based on the proportion of patients served by such hospitals that are low-income patients with special needs. The state would be required to provide data for the computation of an appropriate DSH allotment that does not result in greater expenditures under this title than would have been made if such waiver had not been revoked or terminated.

Effective Date

Upon enactment.

Section 603. Increase in Civil Penalties Under the False Claims Act.

Current Law

The False Claims Act imposes a liability on those who knowingly present or cause to be presented a false or fraudulent claim for payment by the Government. In certain instances, the person may be liable for a civil penalty of not less than $5,000 and not more than $10,000, plus treble damages.

Explanation of Provision

For violations occurring on or after January 1, 2004, the minimum amount of the civil penalty would be increased from $5,000 to $7,500 and the maximum amount would increase from $10,000 to $15,000.

Effective Date

The provision would be effective for violations occurring on or after January 1, 2004.

Section 604. Increase in Civil Monetary Penalties under the Social Security Act.

Current Law

The Office of the Inspector General (OIG) has the authority to impose civil monetary penalties (CMPs) on any person (including an organization or other entity, but not a beneficiary) who knowingly presents, or causes to be presented, to a state or federal government employee or agent certain false or improper claims for medical or other items or services. CMPs may also be imposed for other fraudulent activities such as inflating charges for services, providing services when not a properly licensed physician, billing for medically unnecessary services, falsely certifying that an individual meets the requirements for home health services, and offering or soliciting remuneration to influence the provision of medical services. Depending upon the violation, Section 1128A of the SSA authorizes the imposition of CMPs up to $10,000 for each item or service involved, up to $15,000 for individuals who provide false or misleading information in certain instances, and up to $50,000 per act in other instances as well as treble damages.

Explanation of Provision

The amount of penalties would be increased for violations that occur on or after January 1, 2004. In instances where penalties are limited to $10,000 would be increased to $12,500; those penalties that are limited to $15,000 would be increased to $18,750; and those that are limited to $50,000 would be increased to $62,500.

Effective Date

The provision would be effective for violations occurring on or after January 1, 2004.

Section 605. Extension of Customs User Fees.

Current Law

The U.S. Customs Service, the federal government's oldest revenue collecting agency is responsible for regulating the movement of persons, carriers, merchandise, and commodities between the United States and other countries. Its authority to impose user fees for certain services will lapse on September 30, 2003.

Explanation of Provision

The authority would be extended until September 30, 2013.

Effective Date

Upon enactment.

Section 606. Health Care Infrastructure Improvement.

Current Law

No provision.

Explanation of Provision

A loan program would be established to improve the cancer-related health care infrastructure in certain geographic areas of the United States. Examples of potentially eligible projects would include the construction, renovation, or other capital improvement of any hospital, medical research facility or other medical facility or the purchase of any equipment to be used in a hospital, research facility or other medical research facility. In order to receive assistance, project applicant would be required to: (1) be engaged in research in the causes, prevention, and treatment of cancer; (2) be designated as a cancer center for the National Cancer Institute (NCI) or be designated by the State as the sole official comprehensive cancer effort for the State; and (3) be located in a State that on the date of enactment of this title has a population of less than 3 million individuals. $49 million in budget authority would be authorized for July 1, 2004 through FY2008 to carry out the loan program, $2 million of which may be used each year for administration of the program by the Secretary. Not later than 4 years after enactment, the Secretary would be required to submit to Congress a report summarizing the financial performance of the projects that have received assistance under this program, including recommendations on the future operation of the program.

Effective Date

Upon enactment.

Addition to
Chairman's Modifications To:
The Prescription Drug and Medicare Improvements Act of 2003

Title IV - Medicare Fee-For-Service Provisions

(23) NEW SECTION (page 72)

Adult Day Services Healthcare Demonstration Project for Home Health Beneficiaries

This demonstration project would provide beneficiaries new choices, make Medicare more flexible and increase medicare competition by giving Medicare home health users the option to receive some or all of current Medicare home health benefits in an adult day group setting. Qualified medical adult day providers would be required to meet the same Medicare conditions of participation and quality standards as current home health providers, and would be paid 95% of what home health providers would have been paid for the same patient. Participating adult day providers would also be required to provide medication management, supervised activities, and meals without additional compensation. No changes to current law on Medicare eligibility or services covered.

To further ensure budget neutrality, the Secretary could adjust the payment percentage downward if utilization is higher than projected.

Amendment List

The Prescription Drug and Medicare Improvement Act of 2003

June 12, 2003

Amendments Filed in Senate Finance Committee		
No.	Senator	Summary
1	Hatch #1	Medicaid Coverage Maintenance
2	Nickles #1	Judicial Parity
3	Nickles #2	Out Patient Prescription Drug Improvements
4	Nickles #3	Trustee Report on Medicare's Unfunded Obligations
5	Nickles #4	Medicare Eligibility Age
6	Nickles #5	Change in Cost Sharing Structure
7	Nickles #6	Quality Cancer Care Preservation
8	Snowe/ Lincoln #1	To provide for a national Medicare Prescription Drug Plan Premium
9	Snowe #2	Require a study by the General Accounting Office (GAO) to evaluate the existence of a gap in prescription drug coverage and its affect on Medicare beneficiaries
10	Snowe/Hatch #3	Clarify congressional intent in the Balanced Budget Act of 1997 (BBA) with respect to providing Graduate Medical Education (GME) support to hospitals that incur the cost of resident training programs in non-hospital settings and to provide for a technical correction
11	Kyl-Nickles	To determine the best method of reimbursement for the regional Preferred Provider Organizations (PPOs)
12	Kyl #1	Exempts public safety-net hospitals purchases of inpatient drugs from Medicaid best price calculations
13	Kyl #2	To provide for a competitive bidding reimbursement method for the reimbursement of the regional Preferred Provider Organizations (PPOs)
14	Kyl #3	To provide for a competitive bidding reimbursement method for the reimbursement of the regional Preferred Provider Organizations (PPOs) (with offsets)
15	Kyl #4	To provide for a competitive bidding reimbursement method for the reimbursement of the regional preferred Provider Organizations (PPOs)
16	Kyl #5	Annual reimbursement for states and their health providers for costs

Amendments Filed in Senate Finance Committee		
		associated with providing federally-mandated, but uncompensated, emergency medical treatment to undocumented aliens
17	Kyl #6	Medicare Payment Advisory Commission demonstration project for payment of physician services
18	Kyl #7	Practice expense stabilization for cardio-thoracic surgeons
19	Thomas/ Lincoln #1	Ensuring Access to Mental Health Services for Seniors
20	Santorum #1	Medicare Puerto Rico Hospital Payment Parity 75/25 Blend
21	Santorum #2	Medicare Puerto Rico Hospital Payment Parity
22	Santorum #3	Adult day Services Healthcare Options for Home Health Beneficiaries
23	Santorum #4	Medicare Reimbursement for Critical Access Health Centers
24	Santorum #5	Medicare+Choice Equity and Stabilization
25	Santorum #6	Stabilizing Medicare Payments for Dialysis Treatment
26	Santorum #7	Medicare Coverage of Routine Costs Associated with Certain Clinical Trials
27	Santorum #8	Assuring Timely Access to New Technologies Under Medicare
28	Santorum #9	Faster Recognition of New Technologies Under Medicare Inpatient PPS
29	Santorum #10	Medicaid Coverage Maintenance
30	Frist #1	Authorizing Use of Arrangements to Provide Core Hospital Services under Certain Circumstances
31	Frist #2	Hospice Services Provided by Nurse Practitioners, Clinical Nurse Specialists and Physician Assistants
32	Frist #3	Improvements to Demonstration of Coverage of Chiropractic Services Under Medicare (Section 426)
33	Frist #4	Strike Provisions Establishing a Grant Program for Health Care Infrastructure Improvement (Section 606)
34	Frist #5	Allow Beneficiaries to fill long-term prescriptions at local community pharmacies
35	Frist #6	Establishment of Health Retirement Savings Accounts and Allowance of Penalty-Free Withdrawals for Qualified Retiree Health Expenses
36	Frist #7	Strike Demonstration of Coverage of Chiropractic Services Under Medicare (Section 426)
37	Frist #8	Authorization for Administrator to contract to FEHBP plans under certain circumstances (New Section 426 1860D-13)
38	Smith #1	Amendment to Specialized Medicare + Choice plans for Special Needs Beneficiaries
39	Rockefeller #1	Providing a Medicare-guaranteed benefit to all beneficiaries
40	Rockefeller #2	Protecting Employer Coverage

Amendments Filed in Senate Finance Committee		
41	Rockefeller #3	Protecting Low-income beneficiaries
42	Rockefeller #4	Providing a continuous benefit
43	Rockefeller #5	Equal benefit under traditional Medicare
44	Rockefeller #6	Access to Cancer Therapies Act
45	Daschle #1	Amendment to provide protections for rural beneficiaries
46	Daschle #2	Amendment to ensure that all Medicare beneficiaries are charged a fair and affordable premium for prescription drug plans
47	Daschle #3	Amendment to establish a uniform premium for beneficiaries enrolling in the voluntary prescription drug delivery program
48	Daschle #4	Amendment to protect Medicare beneficiaries' access to the drugs their doctor prescribes
49	Breaux #1	Clinical Psychology Training Amendment
50	Breaux #2	Functional Equivalence Amendment
51	Breaux #3	Physician Ownership and Self-Referral
52	Breaux #4	Hospice Attending Physician Amendment
53	Breaux #5	Health Care Fraud and Abuse Control Account 2004 - 2005
54	Breaux #6	Health Care Fraud and Abuse Control Account 2005 - 2006
55	Conrad #1	Access to a Stable Drug Benefit
56	Conrad #2	Same Contracting Cycle for Fallback Plans as Private Drug-only Plans
57	Conrad #3	Reduce the Number of Times Seniors are Required to Switch Plans
58	Conrad #4	Authorization for the Capital Infrastructure Loan Program
59	Conrad #5	Address Medicare Payment Inequities
60	Conrad #6	Stabilize Medicare Reimbursement for Providers of End Stage Renal Disease (ESRD) Case
61	Conrad #7	Transitional Coverage of Certain Self-Injected Drugs
62	Conrad #8	Cost-Effective and Quality Chronic Care Coordination for Medicare Beneficiaries in Traditional Medicare
63	Graham #1	Repeal of Sick Tax
64	Graham #2	Providing a Medicare-guaranteed benefit to all rural beneficiaries
65	Graham #3	Providing a Medicare-guaranteed comprehensive prescription drug benefit
66	Graham #4	Providing a Medicare-guaranteed comprehensive prescription drug benefit

Amendments Filed in Senate Finance Committee		
67	Graham #5	Timely Implementation
68	Graham #6	Test to determine reliability of model
69	Graham #7	Test to determine reliability of model
70	Graham #8	Test to determine reliability of model
71	Graham #9	Providing a Medicare-guaranteed benefit to all beneficiaries over the age of 75
72	Graham #10	Providing a Medicare-guaranteed benefit to all beneficiaries over the age of 80
73	Graham #11	Providing a Medicare-guaranteed benefit to all beneficiaries over the age of 85
74	Graham #12	Providing a Medicare-guaranteed benefit to all beneficiaries over the age of 90
75	Graham #13	Providing a Medicare-guaranteed benefit to all beneficiaries over the age of 95
76	Graham #14	FEHBP BC/BS Standard Drug Benefit as Basis for Actuarial Equivalent Coverage
77	Graham #15	Limitation on Instability
78	Graham #16	Information for Beneficiaries
79	Graham #17	Provide adequate time frame for contracting
80	Graham #18	Beneficiary Information Provision
81	Graham #19	The Immigrant Children's Health Improvement Act
82	Graham #20	The Immigrant Children's Health Improvement Act
83	Graham #21	Require Prescription Drug Benefit to be Defined
84	Jeffords/ Breaux #1	Removing Barriers to Establishment of Distinct Part Units by Critical Access Hospital Facilities
85	Jeffords #2	Equitable Physician Services Adjustment
86	Jeffords #3	Equitable Funding Adjustments for Home Health
87	Bingaman #1	Remove Assets Test for Low-Income Beneficiaries
88	Bingaman #2	Reducing the Impact on Out-of-Pocket Cost sharing for Low-Income Beneficiaries due to Assets test
89	Bingaman #3	To ensure effective outreach and enrollment of eligible beneficiaries in the prescription drug low-income assistance program
90	Bingaman #4	To provide for increased stability to low-income seniors and disabled in the Medicare program
91	Bingaman #5	Providing Consumer Protections in Health Plans
92	Bingaman #6	Consumer Education and Counseling
93	Bingaman #7	To allow senior in FFS to buy supplemental benefit package that could be offered in Medicap plans

Amendments Filed in Senate Finance Committee		
94	Bingaman #8	Protecting Medicare Disproportionate Share Hospital (DSH) Payments to Safety Net Hospitals.
95	Bingaman #9	Wrap-around Payments to Federally Qualified Health Centers (FQHCs)
96	Bingaman #10	Medicare Incentive Payment Program Improvements
97	Bingaman #11	State Carrier Medical Directors (CMD) in Every State
98	Bingaman #12	Dental Residencies in Medicare GME
99	Bingaman #13	Clarification of Requirements for Counting Residents in Non-Hospital Settings for Medicare GME
100	Bingaman #14	Indian Medicare Technical Amendments
101	Bingaman #15	Indian Contract Health Services and Medicare Payments
102	Bingaman #16	Requiring Guaranteed Drug Option to Native Americans
103	Bingaman #17	Eliminating Overpayments to Medicare Advantage Plans and Improve the Medicare Drug Coverage
104	Bingaman #18	Eliminating Overpayments to Medicare Advantage Plans and Address the Physician Payment Shortfall
105	Kerry #1	Elimination of Coverage Gaps
106	Kerry #2	Medigap to Fill the Gap
107	Kerry #3	Protecting Employer Coverage
108	Kerry #4	Improving the Discount Card for Low-Income Beneficiaries
109	Kerry #5	Administrative Improvements
110	Kerry #6	Fairness for Urban Hospitals
111	Kerry #7	Mental Health Copay Equity Act
112	Kerry #8	Medicare Vision Rehabilitation Services Act
113	Kerry #9	Beneficiary Cost-Sharing Protections
114	Kerry #10	Equity for Puerto Rico
115	Lincoln #1	Better discounts for Seniors - FSS
116	Lincoln #2	Better Discounts for Seniors – Medicaid Best Price
117	Lincoln #3	Providing a Medicare-guarantee benefit to all beneficiaries
118	Lincoln #4	Providing a Medicare-guaranteed benefit to all beneficiaries
119	Lincoln #5	To provide for a national Medicare Prescription Drug Plan Premium
120	Lincoln #6	Ensure Maximum Enrollment in low-income assistance programs
121	Lincoln #7	Help Neediest Seniors – lower coinsurance
122	Lincoln #8	Help Neediest Seniors – increase limit to 175%
123	Lincoln #9	Help Neediest Seniors – increase limit to 200%
124	Lincoln #10	Sense of the Senate that Congress should alleviate the negative impact of the $1,500 therapy cap
125	Lincoln #11	Adult Day Services Health Care Options for Home Health Beneficiaries
126	Lincoln #12	Physical Therapy Direct Access Demonstration
127	Lincoln #13	Geriatrics GME

Amendments Filed in Senate Finance Committee		
128	Lincoln #14	Chronic Care Management
129	Lincoln #15	Insulin Syringe Coverage
130	Lincoln #16	Access to Diabetes Screening Services
131	Lincoln #17	Providing Improved access to osteoporosis testing
132	Lincoln #18	Providing coverage for kidney disease education services
133	Lincoln #19	Providing coverage of marriage and family therapist services and mental health counselor services
134	Lincoln #20	Medicare Coverage of Routine Costs Associated with certain Clinical Trials
135	Lincoln #21	Physician Ownership and Self-Referral
136	Lincoln #22	Medicare Ambulance Payment Reform
137	Lincoln #23	Tricare Access Improvement Amendment
138	Lincoln #24	Expanding the Work of Medicare Quality Improvement Organizations in the New Medicare System

(1)

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Hatch Amendment # 1

Short Title: _____

Amendment Description:
Any State that has above expanded coverage above the minimum income level for low-income Medicare beneficiaries to qualify for full Medicaid coverage will have the federal government assume the cost of Medicare Part A cost-sharing for the beneficiaries that fall into the expanded eligibility category. The Part A costs will be assumed so long as the State maintains the expanded coverage. This provision would only be applied to states who have expanded eligibility levels prior to the enactment of this legislation.

Rationale:
A number of states have taken the OBRA 1986 option to expand full Medicaid coverage to low-income medicare beneficiaries between 74% of the federal poverty (FPL) and 100% of the FPL. This amendment has the federal government assume the state portion of the Medicare Part A cost-sharing for those beneficiaries for the States whose expanded Medicaid coverage is between 74% of the (FPL) and 100% of the FPL. If the State reduces Medicaid coverage levels for this population, the Part A buy-out to the State would be reduced to the same level. This provision would only be applied to States who have expanded eligibility levels prior to the enactment of this legislation.

Contact: Pattie DeLoatche 49850

(2)

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Nickles Amendment # 1

Short Title: Judicial Parity

Amendment Description:

The provision would provide judicial parity for beneficiaries and providers under the Medicare program. Specifically, the provision would provide access for judicial review of non-claims based challenges to final agency actions based on non-compliance with the Administrative Procedures Act, the Congressional Review Act and questions concerning Constitutionality.

This provision would relieve the inappropriate burden placed on the Administrative process designed for payment and claims disputes and redirect this class of cases to a more appropriate setting.

The provision would not allow any claims based cases to be pursued under this process.

The provision would provide the Secretary with presentment of the complaint with an opportunity to cure the issue prior to access to court; would bar any reimbursement cases from the process and would bring Medicare beneficiaries and providers in parity with access to court under Medicaid.

Under current procedures providers are precluded from challenging inappropriate agency actions without violating the agency action and risking debarment from the program and beneficiary classes are precluded from challenging inappropriate agency actions.

(3)

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Nickles Amendment # 2

Short Title: Out Patient Prescription Drug Improvements

Amendment Description:
The provision addresses the flawed reimbursement methodology in the Medicare Hospital Outpatient PPS Rule for drugs and biologics in the hospital outpatient setting.

Specifically, the provision directs CMS to commission a study of hospital acquisition costs on a per product basis in order to have appropriate data available to better establish future annual reimbursement rates for drugs and biologics administered in the hospital outpatient setting. The study will also review the impact of CMS reimbursement rates on access to drugs and biologics in rural areas.

In the interim, the provision would establish reimbursement rates for single source, innovator multi source, and non-innovator multi-source products for 04 and 05 to protect patient access.

Offset:
Extension of the Chairman's Mark Clinical laboratory co-insurance and deductible policy to independent clinical laboratories.

(4)

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Nickles Amendment # 3

Short Title: Trustee Report on Medicare's unfunded obligations

Amendment Description:

The provision would require the Board of Trustees of the Federal Hospital Insurance Fund and the Federal Supplementary Medicare Insurance Trust Funds to include in their 2004 Annual Report an analysis of the Medicare program's total unfunded obligations. This provision would require the Trustee's to include an analysis of the programs' long term obligations compared to the programs' dedicated funding sources (not including general revenue transfers). This would include the combined obligations of the HI, trust fund SMI trust fund and the new Prescription Drug Account.

Explanation

Under the current analysis, the Trustee Report financial assessments for the HI trust fund and the SMI trust funds are separate. This does not provide an adequate analysis of future unfunded obligations. The Trustee's are precluded from such analysis due to the distinct financing methods of the HI and SMI trust funds. Since SMI premium and the corresponding income from general revenue are established annually at a level sufficient to cover the following year's expenditures, the SMI trust fund is automatically in financial balance under present law. This analysis is lacking in that it does not adequately reveal the government's unfunded obligations and therefore the future burden on taxpayers. The current report does not take into account the fact that 75 percent of SMI expenses are not covered by any specific financing source.

5

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Nickles Amendment #4

Short Title: Medicare Eligibility Age

Amendment Description:

Raise the eligibility age to reflect the Social Security full Retirement Age.

6

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Nickles Amendment # 5

Short Title: Change in Cost Sharing Structure

Amendment Description:
The benefit package for the QMB population would be defined as having a zero deductible, cost-sharing of 10% for costs below the initial coverage limit; 10% cost-sharing for costs above the initial coverage limit and below the annual catastrophic limit, and 10% 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, 10% cost-sharing for costs below the initial coverage limit; 10% cost-sharing for costs above the initial coverage limit and below the annual catastrophic limit, and 10% cost-sharing for costs above the catastrophic limit. Plans could waive or reduce cost-sharing otherwise applicable.

Persons with incomes below 160% of poverty, not otherwise eligible for low-income 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% cost-sharing for costs below the initial coverage limit; 20% cost-sharing for costs above the initial coverage limit and below the annual catastrophic limit, and10% cost-sharing for costs above the catastrophic limit. Plans could waive or reduce cost-sharing otherwise applicable.

Contact: Megan Hauck, 4-2465

(7)

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Nickles Amendment # 6

Short Title: Quality Cancer Care Preservation

Amendment Description:
Replace section 420 in underlying mark with provisions from H.R. 1622, the Quality Cancer Care Preservation Act.

Medicare payment for drugs administered in physician offices would be set at 120% of the manufacturer's average sales price (ASP). The increase over the manufacturer's ASP accounts for the wholesaler's markup and drug-related expenses incurred by physicians, such as wastage, opportunity cost of investment in inventory, procurement costs, and bad debt. If a state or locality imposes a sales tax or gross receipts tax on drugs, Medicare would also pay that amount.

ASP would be calculated by considering all discounts and rebates. Prices offered to hospitals, nursing facilities, hospices, HMOs, governmental entities, and charitable organizations would be excluded, since those prices are not necessarily indicative of the prices available to physicians. Manufacturers would report their ASPs to the Centers for Medicare & Medicaid Services (CMS) each calendar quarter, and the amounts would be used to calculate Medicare payments for the second subsequent quarter.

CMS would have the option of setting a payment amount for each drug by the specific drug or, as under the current system, grouping all versions of a multiple-source drug together and paying the same amount for all of them. If a physician actually pays more than the Medicare payment amount for a drug, Medicare would pay the full amount if the physician documents the purchase price, unless CMS finds that the payment amount was unreasonable. Physicians could apply to CMS for additional payments to cover bad debts related to, and costs incurred in billing for, drugs furnished to Medicare patients.

Medicare would pay the full costs of drug administration services. To estimate these costs, CMS would be required to use the estimates of clinical staff time, supplies, and equipment expenses developed in the clinical practice expert panel process. CMS would use the latest available data on staff salaries and supply costs to update those estimates. Direct costs (clinical staff, supplies, and equipment) as so determined would be deemed to be 33.2% of the total costs. That figure is based on CMS data on the ratio of total to direct costs for all physicians, as published in the Federal Register on Aug. 2, 2001 (66 Fed. Reg. 40272, 40377).

CMS would be required to make an additional payment when more than one chemotherapy drug is administered by push technique during the same encounter.

Medicare would make a payment for chemotherapy support services, such as nutrition counseling, psychosocial services, and social worker services, furnished incident to the physician's services.

The payment would be made on a weekly basis with respect to each patient receiving chemotherapy and would be based on the costs of furnishing chemotherapy support services as they are provided in oncology practices that provide these services in a manner that is considered high quality care.

Medicare would be required to establish a new payment amount for physician's services related to the treatment of cancer patients. This amount would pay for the extra work that physicians treating cancer patients must perform before and after seeing the patient. The current visit and consultation codes assume only a small amount of such work because the codes are used by all specialties and for all types of patients.

In addition to drug administration services, there are a number of other services, including radiation oncology services, that do not have a physician work component and therefore are subject to the special "zero physician work pool" payment methodology. This was adopted as an interim payment methodology, but CMS has not yet adopted a final payment method. The bill would require CMS to develop a revised payment methodology that fully pays for the costs of furnishing these services to Medicare patients.

This provision would clarify how services can be billed to Medicare when "direct supervision" by a physician is required. Direct supervision means that a physician must be present in the office suite while the nurse or technician is furnishing the service, but the physician is not required to be with the patient. Drug administration services are subject to the direct supervision requirement.

When direct supervision is required, Medicare allows a physician other than the ordering physician to provide the supervision. Recently, Medicare has indicated that the Medicare claim form should show the billing number of the supervising physician when different from the ordering physician. This creates difficulties for many physician practices. The bill's provision would permit use of the ordering physician's billing number, provided that the medical records identify the supervising physician or physicians.

The bill would require a two-part study by the Institute of Medicine. The first phase would study the current system for delivery of services to cancer patients, prior to the provisions of this bill going into effect. Study elements would include an assessment of access to care; the range of services, including support services, that are and that should be provided to cancer patients; appropriate practice standards; the role of oncology nurses; and development of a framework for assessing the effects of this legislation.

The second phase of the study would use that framework to analyze the effects of this legislation after it has been implemented.

The revised payment rates would go into effect on January 1, 2005. Pharmaceutical manufacturers would begin reporting average sales by October 30, 2004.

The clarification of the policy on billing for services supervised by another physician would be effective upon enactment.

Contact: Megan Hauck, 4-2465

8

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Snowe/Lincoln Amendment # 1

Short Title: To provide for a national Medicare Prescription Drug Plan Premium

Amendment Description:

This amendment amends Section 1860D-16, Payments to Eligible Entities, to add the requirement that payments to plans be geographically adjusted in a budget-neutral manner to account for differences in utilization across service areas.

Contact: Catherine Finley 224-1316

(9)

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Snowe Amendment # 2

Short Title: Require a study by the General Accounting Office (GAO) to evaluate the existence of a gap in prescription drug coverage and its affect on Medicare beneficiaries

Amendment Description:

This amendment calls on the General Accounting Office to conduct a study for calendar years 2006 and 2007 to evaluate the type of coverage options available to Medicare beneficiaries under the voluntary prescription drug delivery program, and to determine if gaps in coverage exist, and if they do exist, to evaluate the impact to beneficiaries of these coverage gaps and offer recommendation to the Secretary of Health and Human Services and Congress about how to minimize or eliminate the coverage gap. The report is to be submitted to Congress no later than June 1, 2008.

Contact: Catherine Finley 224-1316.

(10)

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Snowe/Hatch Amendment #3

Short Title: Clarify congressional intent in the Balanced Budget Act of 1997 (BBA) with respect to providing Graduate Medical Education (GME) support to hospitals that incur the cost of resident training programs in non-hospital settings and to provide for a technical correction

Amendment Description:

This amendment clarifies that to receive Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments for residents in non-hospital locations, the hospital must incur all, or substantially all, the costs of the training in that site from the effective date of a written agreement between the hospital and the entity owning or operating the non-hospital site, and not from the inception of the program. The effective date of the written agreement would be determined according to generally accepted accounting principles. The amendment further clarifies that congressional intent was for "all or substantially all" the costs of the non-hospital site to include the resident's stipends and benefits and other costs, if any, as determined by the parties and to allow programs to be eligible for GME funding if the hospital incurs "all or substantially all" of the costs of the training in the non-hospital location, even if for certain programs "all or substantially all" of the costs might be low because of voluntary faculty or other discounted benefits. Lastly, the amendment provides for a technical amendment to provisions enacted in the BBA that created a three-year rolling average in counting residents and a one-year lag in increasing IME payments. The new language would exempt dental and podiatric residents from these provisions in the same way these residents were exempted from the residency requirements in the BBA.

Contact: Catherine Finley 224-1316

(11)

AMENDMENT
to
PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

Kyl-Nickles Amendment #1 to Chairman's Mark

Description of Amendment: To determine the best method of reimbursement for the regional Preferred Provider Organizations (PPOs).

Current Law: None

Text of Amendment: The amendment uses both the proposal in the Chairman's mark and a competitive bidding methodology of reimbursement the PPOs to determine the correct reimbursement. From 2006 until 2010, in half of the regions of the country with half the population, PPOs would be reimbursed under the methodology in the Chairman's mark. In the other half of the regions of the country, PPOs in each region would bid to provide Medicare benefits. The three lowest bids in each region would be the three plans selected. The middle bid of the three lowest bids would be the benchmark payment rate used by the Secretary. The beneficiary's premium would be set at the Medicare Part B premium for the middle bid. At the end of 2010, the payment methodology that had the most PPOs offering benefits in those particular regions would be adopted nationwide.

Offsets: First, means test the taxpayer subsidy for the Medicare Part B premium. Phase out the taxpayer subsidy of the Part B premium for individuals with incomes between $50,000 and $100,000 and for married couples with incomes between $75,000 and $125,000. This provision was passed by the Senate as part of BBA 97 but was dropped in conference. Second, prohibit the use of SCHIP funds to provide coverage for childless adults. Third, increase SSI review so that in FY2004, the SSI review would be required for 25 percent of all State-determined allowances. In FY 2005 and thereafter, review would be required for at least 50 percent of state determined allowances. These two offsets were passed by the Senate as part of the "Jobs and Growth Tax Relief Reconciliation Act of 2003," but were dropped in conference.

Contact: Don Dempsey, 4-2176

(12)

AMENDMENT
to
PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

Kyl Amendment #1 to Chairman's Mark

Description of Amendment: Exempts public safety-net hospitals purchases of inpatient drugs from Medicaid best price calculations.

Current Law: Safety-net hospitals purchase of outpatient drugs is exempt from Medicaid best price calculations.

Text of Amendment: Amend section 1927(c)(1)(C) of the Social Security Act to also exempt public safety-net hospitals purchase of inpatient drugs from Medicaid best price calculations. Legislative language is the same as S. 1195 introduced by Senator Kyl. This amendment was included as part of S. 3018 in the 107th Congress. CBO scored that provision as a negligible cost.

Contact: Don Dempsey, 4-2176

(13)

AMENDMENT
to
PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

Kyl Amendment #2 to Chairman's Mark

Description of Amendment: To provide for a competitive bidding reimbursement method for the reimbursement of the regional Preferred Provider Organizations (PPOs).

Current Law: None

Text of Amendment: The amendment replaces the payment methodology included in the Chairman's proposal with a bidding methodology. Plans in each region would bid to provide Medicare benefits. The three lowest bids in each region would be the three plans selected. The middle bid of the three lowest bids would be the benchmark payment rate used by the Secretary. The beneficiary's premium would be set at the Medicare Part B premium for the middle bid. This amendment would be offset by appropriate changes in title I of the Chairman's mark.

Contact: Don Dempsey, 4-2176

(14)

AMENDMENT
to
PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

Kyl Amendment #3 to Chairman's Mark

Description of Amendment: To provide for a competitive bidding reimbursement method for the reimbursement of the regional Preferred Provider Organizations (PPOs).

Current Law: None

Text of Amendment: The amendment replaces the payment methodology included in the Chairman's proposal with a bidding methodology. Plans in each region would bid to provide Medicare benefits. The three lowest bids in each region would be the three plans selected. The middle bid of the three lowest bids would be the benchmark payment rate used by the Secretary. The beneficiary's premium would be set at the Medicare Part B premium for the middle bid.

Offsets: First, means test the taxpayer subsidy for the Medicare Part B premium. Phase out the taxpayer subsidy of the Part B premium for individuals with incomes between $50,000 and $100,000 and for married couples with incomes between $75,000 and $125,000. This provision was passed by the Senate as part of BBA 97 but was dropped in conference. Second, prohibit the use of SCHIP funds to provide coverage for childless adults. Third, increase SSI review so that in FY2004, the SSI review would be required for 25 percent of all State-determined allowances. In FY 2005 and thereafter, review would be required for at least 50 percent of state determined allowances. These two offsets were passed by the Senate as part of the "Jobs and Growth Tax Relief Reconciliation Act of 2003," but were dropped in conference.

Contact: Don Dempsey, 4-2176

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AMENDMENT
to
PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

Kyl Amendment #4 to Chairman's Mark

Description of Amendment: To provide for a competitive bidding reimbursement method for the reimbursement of the regional Preferred Provider Organizations (PPOs).

Current Law: None

Text of Amendment: The amendment replaces the payment methodology included in the Chairman's proposal with a bidding methodology. Plans in each region would bid to provide Medicare benefits. The three lowest bids in each region would be the three plans selected. The middle bid of the three lowest bids would be the benchmark payment rate used by the Secretary. The beneficiary's premium would be set at the Medicare Part B premium for the middle bid.

Contact: Don Dempsey, 4-2176

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AMENDMENT
to
PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

Kyl Amendment #5 to Chairman's Mark

Description of Amendment: Annual reimbursement for states and their health providers for costs associated with providing federally-mandated, but uncompensated, emergency medical treatment to undocumented aliens.

Current Law: Section 4723(a) of The Balanced Budget Act of 1997 included a provision that provided $25 million each year for four years to help defray the costs that states and providers incur to provide these federally-mandated emergency health services. The last year funding was available was 2001.

Text of Amendment: Modify current law to provide $1.45 billion a year to health-care providers and states for federally-mandated, but uncompensated, emergency medical treatment to undocumented aliens. Legislative language as contained in S. 412.

Contact: Elizabeth Maier, 4-4521 or Don Dempsey, 4-2176

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AMENDMENT
to
PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

Kyl Amendment #6 to Chairman's Mark

Description of Amendment: Medicare Payment Advisory Commission demonstration project for payment of physician services.

Current Law: Physicians are currently reimbursed by Medicare under the Sustainable Growth Rate (SGR). The SGR expenditure target is projected to reduce payments to physician and other health professionals by 4.2% in 2004, with additional cuts in 2005, 2006, and 2007.

Text of Amendment: Establishes a two-year MedPAC demonstration, with a 2.5% updated in the 2004 physician/practitioner conversion factor followed by an update equal to the increase in the MEI in 2005 and a return to SGR-determined targets in 2006. There would be no allowance for this change in the law and regulation section of the SGR target so that the cost of the proposal essentially would be borne by physicians in the out-years.

Contact: Don Dempsey, 4-2176

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AMENDMENT
to
PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

Kyl Amendment #7 to Chairman's Mark

Description of Amendment: Practice expense stabilization for Cardio-thoracic surgeons.

Current Law: None

Text of Amendment: This amendment requires CMS to recognize the practice expense costs of clinical staff employed by cardio-thoracic physicians (net of any reimbursements for staff for whom there is direct reimbursement under Medicare Part B) regardless of the site of service.

For the purposes of determining costs incurred under this section, the Secretary shall utilize validated data collected by organizations and entities (other than the Department of Health and Human Services) on all costs incurred by physicians, including the data from the Socioeconomic Monitoring System of the American Medical Association and from supplemental surveys, accepted by the Department of Health and Human Services as consistent with sound data practices. The effective date would be January 1, 2004.

Contact: Don Dempsey, 4-2176

(19)

THOMAS/LINCOLN #1

AMENDMENT to: "The Prescription Drug and Medicare Improvement Act of 2003"

Short Title: Ensuring Access to Mental Health Services for Seniors

Amendment Description: Permits licensed professional counselors (LPCs) and marriage and family therapists (MFTs) to bill Medicare for mental health services provided to seniors at the same rate as masters level social workers in accordance with state licensure laws. (S. 310)

Current law only allows psychiatrist, psychologist, social workers and clinical nurse specialists to bill Medicare. However, many rural areas have a difficult time recruiting these types of providers which forces seniors to drive long distances to receive care or to go without.

This provision would take affect on January 1, 2005 and is fully offset with the elimination of CMS's semiannual maintenance payment allowed for capped rental equipment and require them to pay for repairs only when needed. Savings is $500 million.

MFT/LPC/Psychiatrist State-by-State comparison

State	Psychiatrist	MFT	LPC
Iowa	200	182	361
Montana	74	32*	1,916
Wyoming	39	58	296
Louisiana	504	370	1,443
Tennessee	513	247	888
Florida	1,682	1,985	4,316
New Mexico	238	227	2,775
South Dakota	48	154	538
Oklahoma	253	607	1,532
Mississippi	164	339	567
West Virginia	152	20*	1,351
Kentucky	383	410	641
North Dakota	70	21*	374
Utah	180	390	111
Vermont	144	30	314
Pennsylvania	1,982	739	10,053
Oregon	408	1,305	1,138
Maine	204	394	1,295
Massachusetts	2,000	998	4,080
Arkansas	187	164	640
TOTAL	9,425	8,672	34,629

* MFTs are not yet licensed in Montana, West Virginia and North Dakota.

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AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Santorum Amendment # 1

Short Title: Medicare Puerto Rico Hospital Payment Parity 75/25 Blend

Amendment Description:

Under current law, hospitals in Puerto Rico receive reimbursement based on a blend of 50 percent of the Federal rate and 50 percent of the Puerto Rico regional rate. Puerto Rico is the only territory or state that receives a blended payment under the Medicare Prospective Payment System (PPS). All other hospitals were phased into a 100 percent PPS payment utilizing DRGs as the base payment system since 1983.

The amendment would increase the blended payment rate in Puerto Rico from 50 percent Federal Rate and 50 percent Regional Rate to 75 percent Federal Rate and 25 percent Regional Rate, beginning in fiscal year 2004.

Contact: Pete Stein (4-7911)

(21)

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Santorum Amendment # 2

Short Title: Medicare Puerto Rico Hospital Payment Parity

Amendment Description:

Under current law, hospitals in Puerto Rico receive reimbursement based on a blend of 50 percent of the Federal rate and 50 percent of the Puerto Rico regional rate. Puerto Rico is the only territory or state that receives a blended payment under the Medicare Prospective Payment System (PPS). All other hospitals were phased into a 100 percent PPS payment utilizing DRGs as the base payment system since 1983.

The amendment would increase the blended payment rate in Puerto Rico from 50 percent Federal Rate / 50 percent Regional Rate to 100 percent Federal Rate, for fiscal years 2005, 2006, 2007, 2008 and 2009. Current law would resume in fiscal year 2010.

Contact: Pete Stein (4-7911)

22

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Santorum Amendment # 3

Short Title: Adult Day Services Healthcare Options for Home Health Beneficiaries

Amendment Description:

There is no provision under current law.

This amendment would provide beneficiaries new choices, make Medicare more flexible, and increase Medicare competition by giving Medicare home health users the option to receive some or all of current Medicare home health benefits in an adult day group setting. Qualified medical adult day providers would be required to meet the same Medicare conditions of participation and quality standards as current home health providers, and would be paid 95% of what home health providers would have been paid for the same patient. Participating adult day providers would also be required to provide medication management, supervised activities, and meals without additional compensation. No changes to current law on Medicare eligibility or services covered.

To further ensure budget neutrality, the Secretary could adjust the payment percentage downward if utilization is higher than projected.

Contact: Pete Stein (4-7911)

23

AMENDEMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Santorum Amendment # 4

Short Title: **Medicare Reimbursement for Critical Access Health Centers**

Amendment Description:

This amendment would expand and improve access to primary and specialty health care services for the medically underserved by allowing private, religious non-profit health care entities to qualify for cost-based reimbursement under Medicare. The amendment would also provide for a demonstration project to improve health care access to vulnerable populations.

Under current law, health center that does not receive Public Health Service Act (PHSA) section 330 grant funding (i.e., a community health center) but meets the statutory requirements for receiving section 330 grant funds is eligible for designation as a Federally Qualified Health Center (FQHC) Look Alike. The Medicare benefits associated with being designated an FQHC Look Alike include waiver of the Medicare Part B deductible for Medicare patients, waiver of the part B co-payment for beneficiaries with incomes below 200 percent of poverty, and cost based reimbursement.

Religious sponsored private, non-profit health centers are unable to qualify for FQHC Look Alike status because of a section 330 governance requirement that a majority of a community health center's board must be composed of users of the health center. PHSA section 330 already provides exemptions from the governance requirement for Indian tribes, public agencies, sparsely populated areas, and for programs for special populations such as migrant and seasonal workers, homeless people, and residents of public housing.

Beginning in FY 2005, this amendment would provide that Critical Access Health Centers be eligible to qualify for the same benefits under the Medicare program as FQHC Look Alike centers. A Critical Access Health Center is defined as a private non-profit entity with a religious affiliation that meets all the statutory requirements for section 330 grants except for the governance requirement that 51 percent of a health center's board be composed of users of the health center.

The amendment would further provide for a demonstration project to assess the use of alternative payment methodologies to health care providers to improve access to

ambulatory health care services and continuity of care for vulnerable populations, such as low-income Medicare beneficiaries.

Contact: Pete Stein (4-7911)

24

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Santorum Amendment # 5

Short Title: Medicare+Choice Equity and Stabilization

Amendment Description:

The amendment would provide for more equitable reimbursement rates under the Medicare program for Medicare+Choice organizations by making several changes to the M+C payment formula.

Under current law, Medicare+Choice plans are paid a monthly premium payment amount (M+C payment rate), for each enrollee. The payment area is the highest of three amounts: 1) a minimum payment (floor) rate; 2) a blend of an area-specific (local) rate and a national rate; or 3) a minimum increase of 2% from the prior year's rate. Each year, the three payment amounts are updated by formulas set in statute.

This amendment would provide:

1. Equalizing Payments Between Fee-for-Service and Medicare+Choice. Add the option for Medicare+Choice plans to be paid at 100% fee-for-service rates, factoring in indirect medical education costs and excluding direct graduate medical education costs in that amount.
2. Revision of Blend. Allow for the national portion of the blend payment rate to be determined based on M+C enrollment rather than Medicare enrollment. In addition, eliminate the application of budget neutrality to the blend.
3. Revision in Minimum Percentage Increase. Increase the minimum update payment amount from 2% to 4%.

The amendment shall take effect January 1, 2004.

Contact: Pete Stein (4-7911)

25

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Santorum Amendment # 6

Short Title: Stabilizing Medicare Payments for Dialysis Treatment

Amendment Description:

The current Chairman's Mark provides, consistent with MedPAC recommendations, for a 1.6% increase in the composite rate for dialysis treatments in both 2004 and 2005.

This amendment would establish an annual update framework for the ESRD program effective in 2006.

The amendment would also reimburse separately billable ESRD drugs and biologics consistent with reform of the Part B Average Wholesale Price (AWP) payment methodology, and correspondingly increase the composite rate in a budget-neutral manner. The amendment would define budget neutral to be an amount equivalent to the projected, aggregate amounts that would have been otherwise payable in the applicable payment period to dialysis facilities for separately billable drugs and biologics, assuming the current law drug and drug administration payment methods had continued in effect unchanged.

In addition, the amendment would provide that the implementation of bundling would be dependent upon the receipt of: 1) the Secretary's Report to Congress and recommendations pursuant to the requirements of Pub.L. No. 106-554, § 1(a)(6) [Title IV, § 422(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A-517, addressing modifications to the payment methods for ESRD program services in the future; and 2) findings from the ESRD disease management demonstrations currently underway.

Pay-For / Offset:

Extend Medicare Secondary Payor provisions from 30 months to 36 months to offset costs associated with adoption of the annual update framework for the ESRD program, effective in 2006 and beyond.

Contact: Pete Stein (4-7911)

(26)

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Santorum Amendment # 7

Short Title: Medicare Coverage of Routine Costs Associated With Certain Clinical Trials

Amendment Description:

Medicare pays for the routine costs of FDA-approved clinical trials (both drugs and devices) - - except for a small number of approved breakthrough device trials. Despite a 2000 announcement that CMS would implement a presidential executive order to provide reimbursement for the routine costs of care for breakthrough technologies, the policy has not been implemented. This delay is impeding development of potentially life-saving technologies, like heart assist devices, for Medicare patients in need of new treatment options.

The amendment would direct CMS to keep its commitment to cover the routine costs of clinical trials of breakthrough medical technologies. This policy would have a minimal impact on Medicare spending (breakthroughs represent only six percent of FDA-approved studies) but a huge impact on Medicare patients awaiting emerging breakthroughs like implantable artificial hearts, bioartificial livers and kidneys and "bionic eyes" to treat blindness.

The amendment would require the Secretary to deem FDA-approved clinical trials as automatically qualified for coverage of routine costs associated with such clinical trials. Nothing in this Section shall be construed as authorizing or requiring the Secretary to modify the current policy with respect to coverage of, or payment for, a medical device subject to a clinical trial subject of an FDA IDE exemption.

Contact: Pete Stein (4-7911)

(27)

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Santorum Amendment # 8

Short Title: Assuring Timely Access to New Technologies Under Medicare

Amendment Description:

Serious delays exist in the amount of time it takes Medicare to make new medical technologies and procedures available to beneficiaries. Problems in Medicare's national coverage process have contributed to delays of up to five years in making new technologies. Currently, Medicare can take 15 months or more to issue procedure codes used by physicians to submit claims. It often takes the agency two years or more to establish proper codes and reimbursement for new technologies used in the hospital inpatient setting.

The amendment would impose deadlines for making and implementing national determinations, including the assignment of codes and updating of relevant payment systems. Under this provision, unless a technology assessment or advisory committee meeting is necessary, the Secretary must make and implement a national coverage determination within 6 months of a request. If either an assessment or a committee meeting is necessary, the deadline will be a year. The required implementation of a national coverage determination includes all of the steps necessary for payment to begin, including such steps as making a determination of what code, if any, is assigned to the particular item or service and a determination with respect to the payment amount.

To obtain that six-month extension, the Secretary must reasonably find, in a written notice issued before the end of the six-month period, that a formal, written technology assessment by a party outside of the Center for Medicare and Medicaid Services ("CMS") or a review by the Medicare Coverage Advisory Committee is necessary for the Secretary to make the determination.

In the event the Secretary determines that he cannot take all of the required actions with the six-month period or one-year period, the Secretary will issue a notice that includes an identification of the substantive issues that remain, the steps necessary to resolve those issues, and the deadline by which all required actions shall be completed.

In making the national determination, the Secretary will issue either (1) a national coverage determination, with or without limitations, (2) a national non-coverage determination, or (3) a determination that no national coverage or non-coverage determination is appropriate as of that time.

The amendment would also require the Secretary to establish a Council on Technology and Innovation in CMS. The Council shall have as its purpose the coordination of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new therapies, to help support patient access to such technologies and procedures. The Council will be chaired by an Executive Coordinator who shall be a non-career appointee designated by the Secretary.

In carrying out that purpose, the Executive Coordinator will be responsible for (1) monitoring the decision-making of CMS on coverage, coding and payment for new items or services, (2) serving as a point of contact for outside groups and entities regarding coverage, coding and payment processes under this title, and (3) preparing reports to Congress on the timeliness of coverage, coding and payment decisions.

The amendment would further require that any agreement with an organization or agency to provide the functions of local medical review determinations under Medicare Part A or Medicare Part B, respectively, must provide that such contractor shall designate at least one individual to serve as medical director for every two States (or portions thereof) to perform such local medical review functions. Further, each contractor must appoint an advisory committee with respect to each such state to perform the same functions that carrier advisory committees played before the enactment of this section.

Contact: Pete Stein (4-7911)

(28)

AMENDMENT
to
The Medicare Prescription Drug and Medicare Improvement Act of 2003

Santorum Amendment # 9

Short Title: Faster Recognition of New Technologies Under Medicare Inpatient PPS

Amendment Description:

Medicare typically takes two years or more to update its inpatient reimbursement rates to reflect changes in medical technology. To reduce these delays, Congress passed legislation as part of the Benefits Improvement and Protection Act of 2000 (BIPA) establishing special transitional payments for new medical technologies used in the inpatient setting. However, CMS implemented this legislation so narrowly it failed to fulfill Congressional intent. In fact, only one new drug has qualified for the temporary payments. The amendment would ensure that, whenever possible, new technologies are placed into existing inpatient payment categories (DRGs) that provide adequate reimbursement. If no appropriate DRG exists, Medicare should create a new DRG or provide a temporary additional payment to cover the costs of a new technology.

The amendment specifies that the Secretary would not be able to deny a service or technology treatment as "new" if the service or technology has been available for marketing use and at the same time subject to an inpatient code that enables the collection of data representing a significant sample of specific discharges involving the service for a period of less than 2-3 years.

Before establishing an additional payment as the appropriate reimbursement mechanism, the Secretary would be directed to take into account similar clinical or anatomical characteristics and the relative cost of the technology when assigning the technology to a DRG. The Secretary would assign an eligible technology into a DRG whose average cost of care most closely approximates the cost of the new technology.

The amendment also changes the threshold for eligibility and changes the reimbursement from 50% to 80%. The Secretary would further be required to deem that a technology provides substantial improvement on an existing treatment if the technology is designated by FDA for fast track, expedited, or priority review or designated for rare diseases and conditions.

The amendment also provides that the budget neutrality requirement with respect to annual DRG reclassifications and recalculation of associated DRG weights would not be affected by these provisions.

Contact: Pete Stein (4-7911)

(29)

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Santorum Amendment # 10

Short Title: Medicaid Coverage Maintenance

Amendment Description:

A number of states have taken the OBRA 1986 option to expand full Medicaid coverage to low-income medicare beneficiaries between 74% of the federal poverty (FPL) and 100% of the FPL.

This amendment would provide that any State that has expanded coverage above the minimum income level for low-income medicare beneficiaries to qualify for full Medicaid coverage will have the federal government assume 50% of the cost of Medicare Part A cost-sharing for the beneficiaries that fall into the expanded eligibility category. The Part A costs will be assumed so long as the State maintains the expanded coverage. This provision would only be applied to states who have expanded eligibility levels prior to the enactment of this legislation.

This amendment has the federal government assume the 50% of the state portion of the Medicare Part A cost-sharing for those beneficiaries for the States whose expanded Medicaid coverage is between 74% of the (FPL) and 100% of the FPL. If the State reduces Medicaid coverage levels for this population, the Part A buy-out to the State would be reduced to the same level. This provision would only be applied to States who have expanded eligibility levels prior to the enactment of this legislation.

Contact: Pete Stein (4-7911)

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AMENDMENT
to
S. _____
The Prescription Drug and Medicare Improvement Act of 2003

Frist Amendment # 1

Short Title: Authorizing Use of Arrangements to Provide Core Hospice Services Under Certain Circumstances

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Current law: *A Medicare hospice program is generally required to provide certain core services directly through its hospice employees.*

Amendment Description: In extraordinary, exigent or other non-routine circumstances such as staffing shortages, inordinately high patient load periods, lack of availability of specialty staff or temporary travel of a patient outside the program service area, a hospice program may enter into an arrangement with another hospice program for provision of similar services. In addition certain highly specialized services could be provided under contract with the direction and supervision of the hospice, on an as needed basis. In all circumstances, the hospice contracting for such services would continue to maintain financial and professional management responsibility for all services furnished the beneficiary, regardless of who provided services or the location in which they were furnished. Permitting a hospice to subcontract for core services under these limited circumstances assures that trained hospice staff or specially trained nurses will provide the services and that the services provided are appropriate within the context of the Medicare hospice benefit. The amendments made by this section shall apply to hospice care provided on or after the date of the enactment of this Act

Contact: Dean A. Rosen
Phone: 224-5589

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AMENDMENT
to
S. _____
The Prescription Drug and Medicare Improvement Act of 2003

Frist Amendment # 2

Short Title: Hospice Services Provided by Nurse Practitioners, Clinical Nurse Specialists and Physician Assistants

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Current Law: *Beneficiaries who elect the Medicare hospice benefit can continue to receive care from the attending physician who they identify as having the most significant role in the determination and delivery of Medicare care to them at the time they elect hospice.*

Amendment Description: Beneficiaries who elect the Medicare hospice benefit could continue to receive care from the primary health care provider who they identified as having the most significant role in the determination and delivery of Medicare care to them at the time they elect hospice care. The primary health care provider would not be limited to attending physician but would also include nurse practitioners, nurse clinicians and physician assistants, who were not employed by the hospice program, if they were acting within the scope of practice under relevant state law. In rural areas, this provision would enhance the continuity of care for patients receiving care by these providers. The amendments made by this section shall apply to hospice care provided on or after the date of the enactment of this Act

Contact: Dean A. Rosen
Phone: 224-5589

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AMENDMENT
to
S. _____
The Prescription Drug and Medicare Improvement Act of 2003

Frist Amendment # 3

Short Title: Improvements to Demonstration of Coverage of Chiropractic Services Under Medicare (Section 426)

Amendment Description:

The amendment would make the following modifications to the Demonstration of Chiropractic Services under Medicare provision in the Prescription Drug and Medicare Improvement Act of 2003, as follows:

(a) The Secretary may require that any eligible beneficiary participating in the chiropractic demonstration project be required to receive approval by a physician (medical doctor or doctor of osteopathy) in order to receive chiropractic services under the demonstration project;

(b) The Secretary would be required to consult with chiropractors, organizations representing chiropractors, beneficiaries and organizations representing beneficiaries, *as well as physicians (medical doctors or doctors of osteopathy) and organizations representing physicians (medical doctors or doctors of osteopathy), including those who have appropriate board certification in the treatment of musculoskeletal diseases and conditions,* in establishing the demonstration projects; and

(c) The Secretary would be required to evaluate the demonstration projects to determine (1) whether the participating beneficiaries used fewer Medicare covered services than those who did not participate; (2) the cost of providing such chiropractic services under Medicare; *and* (3) *the quality of care, including outcome studies, level of patient safety, complications requiring additional Medicare services, and satisfaction of participating beneficiaries.*

Contact: Dean A. Rosen
Phone: 224-5589

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AMENDMENT
to
S. _____
The Prescription Drug and Medicare Improvement Act of 2003

Frist Amendment # 4

Short Title: Strike Provisions Establishing a Grant Program for Health Care Infrastructure Improvement (Section 606)

Amendment Description:

The amendment would strike section 606 of the Prescription Drug and Medicare Improvement Act of 2003, which seeks to establish a unique loan program for certain capital costs, including construction and renovation, of certain medical facilities located in states with populations of less than 3 million individuals.

Contact: Dean A. Rosen
Phone: 224-5589

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AMENDMENT
to
S. _____
The Prescription Drug and Medicare Improvement Act of 2003

Frist Amendment # 5

Short Title: Allow Beneficiaries to fill long-term prescriptions at local community pharmacies

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Amendment Description:

The amendment would modify New Section 1860-D: Beneficiary Protections. Within prescription drug plans, including MedicareAdvantage plans that offer mail order benefits, beneficiaries would have the option to fill long term prescriptions in community pharmacies. Under such circumstances, the pharmacy may charge beneficiaries a differential copay or other charge not to exceed the difference between the mail order reimbursement rate and the applicable pharmacy reimbursement rate adequate to cover the cost of this service.

Contact: Dean A. Rosen
Phone: 224-5589

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AMENDMENT
to
S. _____
The Prescription Drug and Medicare Improvement Act of 2003

Frist Amendment # 6

Short Title: Establishment of Health Retirement Savings Accounts and Allowance of Penalty-Free Withdrawals for Qualified Retiree Health Expenses

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Amendment Description:

The amendment has two main provisions, as outlined below.

I. Permit tax- and penalty-free distributions from tax-favored retirement plans for "qualified retiree health expenses."

Individuals who have reached or are nearing retirement will not have an adequate opportunity to save money for their retiree health care expenses. The proposal would permit individuals who have reached age 55 to make tax- and penalty-free withdrawals from tax-favored retirement accounts for the purpose of paying certain retiree health care expenses.

- Eligible individuals could receive penalty-free distributions for certain retiree health expenses from tax-qualified plans under Code sections 401(a) and 403(a), tax-deferred annuities under Code section 403(b), eligible Code section 457(b) plans maintained by governmental employers, IRAs under Code section 408, and Roth IRAs under Code section 408A (to the extent such Roth IRA distributions are not already excludable).

- In general, eligible individuals would be those individuals who have attained age 55.

- The exclusion would apply with respect to a distribution only to the extent the distribution does not exceed the amount paid during the taxable year for "qualified retiree health expenses" for the individual, the individual's spouse and dependents (as defined in Code section 152). Individuals would be required to claim the exclusion and substantiate their qualified retiree health expenses.

- For individuals age 55 up to age 65, the term "qualified retiree health expenses" would mean those amounts paid for insurance covering medical care as defined in Code section 213(d)(1)(D), including premiums for a

qualified long-term care insurance contract. "Qualified retiree health expenses" for such individuals would also include any co-pays, deductibles, or other non-covered expenses associated with such insurance. Qualified retiree health expenses for such individuals would not include amounts paid for insurance substantially all of the coverage of which is excepted benefits described in Code section 9832(c) (e.g., dental- or vision-only coverage), other than premiums for a qualified long-term care insurance contract (subject to the limits set forth in Code section 213). Further, such individuals would qualify for the exclusion only if they are not (1) entitled to benefits under Medicare Part A, (2) enrolled in Medicaid, SCHIP, VA, Champus, or FEHBP, or (3) covered under subsidized employer health coverage (defined as over 50% of the cost of which is paid by the employer of the individual or the individual's spouse).

- For individuals who are age 65 or older, "qualified retiree health expenses" would mean amounts paid for prescription drugs, qualified long-term care services, deductibles, or co-pays, to the extent such amounts are not compensated by insurance or otherwise. Qualifying retiree health expenses of such individuals would also include premiums for Medigap, or a qualified long-term care contract, but would not include other premiums for health insurance (because such individuals will be covered by Medicare).

II. Allow workers to make pre-tax contributions into a retiree health "side-car" account in a 401(k), 403(b), or governmental 457 plan, or under an IRA.

Individuals who are a number of years before retirement should be permitted to save on a pre-tax basis during their working years for health expenses they will incur when they stop working. Accordingly, the second part of the proposal would create retiree health "side-car" accounts to allow individuals to pre-fund for their retiree health expenses.

- Individuals would be permitted to make additional pre-tax contributions to a retiree health "side-car" account under a 401(k) plan, tax-deferred annuity under Code section 403(b), eligible Code section 457(b) plan maintained by a governmental employer, or IRA under Code section 408. Individuals also would be permitted to make additional after-tax contributions to a retiree health side-car account in a Roth IRA under Code section 408A.

- The decision to invest in a traditional IRA or a Roth IRA would be at the option of the individual.

- The annual contribution limit will track the current IRA limits. The current. income limits applicable to traditional and Roth IRAs will apply. Indexation currently applicable to traditional and Roth IRAs for both contribution and income limits would be applied to qualified retiree health accounts

- Individuals could elect to contribute to a retiree health side-car account in a 401(k), 403(b), governmental 457 plan, IRA, or Roth IRA, but an individual's aggregate side-car contributions to all such accounts for a year could not exceed the individual's applicable limit for the year. All employee contributions would be nonforfeitable at all times.

- Similar to catch-up contributions as enacted by EGTRRA, employee contributions to a side-car account would not be subject to (or be taken into account in applying) the otherwise applicable IRA limit, section 402(g) limit, section 415 limit, section 457(b) limit, or any other contribution limit.

- As with catch-up contributions, employee contributions to a side-car account would not be subject to the otherwise applicable nondiscrimination rules (e.g., the ADP test in 401(k) plans). In employer-sponsored plans, there would, however, be a "universal availability" requirement like that in the catch-up rules, except that disaggregation testing rules similar to those in Code section 410(b) would apply (e.g., collectively bargained plans could be disaggregated).

- Employers could make matching contributions to the accounts, but matching contributions would be subject to any otherwise applicable nondiscrimination rules (e.g., the ACP test in 401(k) and 403(b) plans).

- AGI limits currently applicable to IRAs and Roth IRAs would apply with respect to an individual's eligibility to contribute to a side-car account.

- Tax-free distributions from side-car accounts would only be allowed for qualified retiree health expenses, as defined in part I of the proposal. Distributions for any other purpose would be includable in income -- and generally would not be eligible for rollover (except as provided below) -- and would be subject to a 15% penalty tax, except that penalty-free distributions could be made on account of death, *or* disability.

- Tax-free rollovers could only be made to another retiree health side-car account of the individual.

- Excess contributions (with any income allocable thereto) could be distributed by the due date for filing the individual's return for the year. Undistributed excess contributions would be treated in the same manner as excess contributions to the underlying plan (e.g., excess contributions to an IRA side-car account would be subject to a 6 percent penalty tax as set forth in Code section 4973).

- Otherwise applicable spousal consent and joint and survivor annuity rules would apply.

- The age 70-1/2 minimum required distribution rules would not apply.

- Upon death, the following rules would apply:
  - The individual's spouse could take over the side-car account as his or her own, or could roll it over to the spouse's retiree health side-car account in another plan or IRA.
  - The individual's spouse or dependents could receive tax-free distributions from the decedent's side-car account to the extent the distributions are for medical care as defined in Code section 213(d).
  - If the account balance is less than $5,000, the account balance could be cashed out to the participant's spouse or designated beneficiary, who would pay income tax on the distribution but not a penalty tax.
  - If there is no spouse or dependents, distributions of the side-car account balance would be made to the individual's designated beneficiary or estate in the absence of a beneficiary designation. Such distributions would be subject to income tax but not to a penalty tax.
- Generally, except as otherwise indicated in the Code or by Treasury regulation, the rules that otherwise apply to the IRA, 401(k), 403(b), or governmental 457 plan would also apply to a retiree health side-car account in that account/plan. For example, the rules regarding timing of contribution elections and any limitations on investments (e.g., no IRA investments in collectibles) would apply.

Contact: Dean A. Rosen

Phone: 224-5589

(36)

AMENDMENT
to
S. _____
The Prescription Drug and Medicare Improvement Act of 2003

Frist Amendment # 7

Short Title: Strike Demonstration of Coverage of Chiropractic Services Under Medicare (Section 426)

Amendment Description:

The amendment would strike the Demonstration of Chiropractic Services under Medicare provision in the Prescription Drug and Medicare Improvement Act of 2003.

Contact: Dean A. Rosen
Phone: 224-5589

37

AMENDMENT
to
S. _____
The Prescription Drug and Medicare Improvement Act of 2003

Frist Amendment # 8

Short Title: Authorization for Administrator to contract with FEHBP plans under certain circumstances (New Section 426 1860D-13)

Amendment Description:

Under Section 426 1860D-13, the Administrator of the Center for Medicare Choices is required to take a number of steps, including reducing the amount of risk required by plans in a region, if at least two plans do not meet the minimum requirements for accepting risk. If, after these measures are taken, there are less than 2 approved plan bids by September 1 of each year, the Administrator would enter into an annual contract with an entity to provide Part D enrollees in an area with standard coverage for the following year.

This amendment would allow the Administrator to enter into an arrangement for the provision of such coverage with a risk bearing health insurance issuer providing coverage to federal workers and retirees under the Federal Employees' Health Benefit program or network established by such issuer, including a private fee-for-service plan, to ensure the provision of coverage to eligible beneficiaries in such area. As a prerequisite to the Administrator entering into such an arrangement, the Administrator and the Director of the Office of Personnel Management shall make a joint determination that such arrangement will not have an adverse impact on the health coverage provided to federal workers and retirees enrolled in such plan under the FEHBP during the contracting period.

Contact: Dean A. Rosen
Phone: 224-5589

38

AMENDMENT

to

The Prescription Drug and Medicare Improvement Act of 2003

Smith Amendment #1

Short Title: Amendment to Specialized Medicare + Choice plans for Special Needs Beneficiaries

Amendment Description/Change in Law

This amendment seeks to broaden the group of health plans that are focused on caring for the frail elderly that are included in Section 222 of the chairman's mark. It also seeks to broaden special needs beneficiaries to include those residing in a continuing care retirement community (as defined in Section 1852 (1) (4) (B)). The chairman's mark creates a new category of specialized Medicare+Choice plans that exclusively enroll institutionalized, dual eligible, or other chronically-ill beneficiaries as defined by the Secretary. This amendment increases the number and types of health plans that can offer this new type of choice for beneficiaries to include health plans that serve a disproportionate share of institutionalized, dual eligible, nursing home certifiable, or other chronically ill beneficairies. Like the original provision, this amendment does not change any of the current Medicare+Choice quality and oversight regulations, or change payment.

Effective Date

Effective upon enactment of the bill, through January 1, 2008.

Reason for Change

Currently, there are many different kinds of specialized health plans who provide a comprehensive range of services to frail elderly and chronically-ill beneficiaries. These health plans have successfully demonstrated improved outcomes and more efficient delivery of health care for this vulnerable population through federal demonstrations and independent studies. This amendment seeks to broaden the group of programs who would be allowed to operate without a federal demonstration, including Social HMOs, the Wisconsin Partnership Plan, and the Minnesota Senior Health Options program. The original legislation already allowed plans such as Evercare to offer choices under this new authority.

Contact: Alison Buist, 4-3753

39

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003.

Rockefeller Amendment # 1

Short Title: Providing a Medicare-guaranteed benefit to all beneficiaries

Amendment Description

The underlying mark provides a drug benefit through private drug-only insurance plans or managed care plans. If at least two private insurance plans do not emerge in an area of the country, the government will provide a drug benefit to the seniors in that area through the Medicare program. This amendment would make the Medicare-guaranteed standard benefit with a national premium available to all Medicare beneficiaries from the beginning of the program.

Offset to be determined.

Contact: Yvette Shenouda/4-7993

40

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003.

Rockefeller Amendment # 2

Short Title: Protecting Employer Coverage

Amendment Description

The Chairman's mark does not count payments made on the beneficiaries' behalf by entities other than the beneficiary towards reaching the stop-loss. As a result, CBO assumes that about one-third of all people with employer coverage will lose their employer drug benefit once this plan comes into place. This amendment would count any contributions to drug costs made on the beneficiaries' behalf or by the beneficiary toward the catastrophic limit. Offset to be determined.

Contact: Yvette Shenouda/4-7993

41

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003.

Rockefeller Amendment # 3

Short Title: Protecting Low-income beneficiaries

Amendment Description

Since 1965, Medicare has provided a universal benefit to all of its beneficiaries. It is the promise that society made to our seniors: if you work and make your payroll contributions, then you get Medicare - regardless of where you live, how old you are, or your income. The Chairman's mark, for the first time in the history of the program, would prohibit some Medicare beneficiaries from receiving a Medicare benefit. It would exclude Medicare beneficiaries who also qualify for Medicaid from participating in the Medicare prescription drug benefit. It would leave low-income seniors in Medicaid for prescription drugs, despite governors' unanimous opposition to continuing to pay for this group. It would create a two-tiered system for seniors, which may ultimately mean that those who are most vulnerable - seniors with the lowest income and nursing home residents - could experience worse access to needed prescription drugs. And, it is a step backwards from the universal benefit embraced on a bipartisan basis in all major bills last year.

This amendment would make the Medicare prescription drug benefit a universal benefit by adopting the provisions in the Tripartisan proposal introduced last summer. It would eliminate the exclusion of Medicaid beneficiaries and make the new Medicare Part D drug benefit available to all Medicare beneficiaries regardless of income. It would have Medicaid be secondary payer for Medicare beneficiaries eligible for Medicaid, wrapping around the new Part D drug benefit and its low-income protections. And, it would provide state fiscal relief from the growing fiscal responsibility for providing and administering prescription drug benefits for low-income Medicare beneficiaries.

This amendment, which mirrors last year's Tripartisan proposal, would include two changes:

1. All Medicare beneficiaries would be eligible to participate in the new Part D Medicare drug benefit including those who are eligible for Medicaid. As with any other benefit, Medicare would be primary payer for prescription drugs.

2. Medicaid would be secondary payer for those Medicare beneficiaries who are also eligible for Medicaid. Offset to be determined.

Contact: Yvette Shenouda/4-7993

42

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003.

Rockefeller Amendment # 4

Short Title: Providing a continuos benefit

Amendment Description

The standard benefit in the underlying mark contains a large gap in coverage. This amendment closes that gap to ensure that Medicare beneficiaries receive a continuos drug benefit. Offset to be determined.

Contact: Yvette Shenouda/4-7993

43

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003.

Rockefeller Amendment # 5

Short Title: Equal benefit under traditional Medicare

Amendment Description

The underlying mark requires PPOs to provide beneficiaries with a catastrophic limit on expenditures for medical benefits as well as other additional benefits. Such benefits are not made available to beneficiaries remaining in traditional Medicare. This amendment would allow the provision of these additional benefits through the traditional Medicare program as well with no extra cost to the program. Offset to be determined.

Contact: Yvette Shenouda/4-7993

44

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003.

Rockefeller Amendment # 6

Short Title: Access to Cancer Therapies Act

Amendment Description

Currently, Medicare covers oral anti-cancer drugs only if they are the equivalent of an injectable drug. This amendment expands Medicare's current drug benefit to include all anti-cancer drugs whether oral or injectable under Medicare Part B. Offset to be determined.

Contact: Yvette Shenouda/4-7993

45

AMENDMENT

to

The Prescription Drug and Medicare Improvement Act of 2003

Daschle Amendment # 1

Short Title: Amendment to provide protections for rural beneficiaries.

Amendment Description: The amendment would require that the Administrator, before approving prescription drug plans:

- provide that rural beneficiaries do not pay more in premiums for a prescription drug plan than urban beneficiaries;
- provide that rural beneficiaries have access to no less in prescription drug benefits than urban beneficiaries;
- provide that rural beneficiaries have access to their local pharmacy without a financial penalty;
- provide that rural beneficiaries who are enrolled in the Medicare-guaranteed fallback can keep that plan and not be required to change plans if private drug only plans become available.

Contact: Jane Loewenson or Kate Leone 4-0055

46

AMENDMENT

to

The Prescription Drug and Medicare Improvement Act of 2003

Daschle Amendment # 2

Short Title: Amendment to ensure that all Medicare beneficiaries are charged a fair and affordable premium for prescription drug plans.

Amendment Description: The amendment would provide that beneficiaries cannot be charged more than 5% above the national average monthly premium.

Contact: Jane Loewenson or Kate Leone 4-0055

47

AMENDMENT

to

The Prescription Drug and Medicare Improvement Act of 2003

Daschle Amendment # 3

Short Title: Amendment to establish a uniform premium for beneficiaries enrolling in the voluntary prescription drug delivery program.

Amendment Description: The amendment would provide that beneficiaries, regardless of where they live, pay the same premium for their prescription drug plan.

Contact: Jane Loewenson or Kate Leone 4-0055

48

AMENDMENT

to

The Prescription Drug and Medicare Improvement Act of 2003

Daschle Amendment # 4

Short Title: Amendment to protect Medicare beneficiaries' access to the drugs their doctor prescribes.

Amendment Description: The amendment would provide that beneficiaries who are forced to switch prescription drug plans involuntarily, do not have to switch the medications they take and cannot be financially penalized for this protection.

Contact: Jane Loewenson or Kate Leone 4-0055

49

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Breaux Amendment # 1

Short Title: **Clinical Psychology Training Amendment**

Current Law:
The Medicare program provides payments to hospitals for costs of approved educational activities of allied health professionals pursuant to 42 CFR section 413.85. Clinical psychology internship training programs are excluded under this provision due to existing provider-operated criteria.

Amendment Description:
Amend Medicare statute to provide payments to hospitals for costs of approved educational activities of clinical psychology internship training programs under the allied health professional training provisions. Such approved educational activities shall include only the provider-operated one-year clinical training portion of professional educational psychology training. This provision would begin in 2004 and CMS has estimated cost for the next five years at $150 million (66 Fed. Reg. 3377).

Rationale:
Hospital-operated clinical psychology internship programs provide valuable and unique services to Medicare beneficiaries. Hospitals are reducing these programs due in part to the lack of Medicare funding for these programs.

Regarding their training, clinical psychologists are distinguishable from other health care professionals in that they are the only doctoral level mental health professionals fully participating in Medicare whose clinical training is not currently reimbursed. In addition, their clinical internship training is entirely controlled, administered, supervised, evaluated, and certified by the hospital or institution, separately accredited, and distinct from any university training they receive. Clinical psychologists are hospital-based in the final stages of their training functioning in a parallel status to medical interns and residents, not medical nursing or health professional students. Reimbursement is to be provided only where a clinical psychologist has clearly finished his educational curriculum and is training solely in the hospital setting.

Contact: Sarah Walter or Paige Jennings, 4-4623

50

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Breaux Amendment #2

Short Title: **Functional Equivalence Amendment**

Current Law:
None

Amendment Description:
The amendment establishes that the Secretary shall not publish regulations prospectively adopting or applying a "functional equivalence" or similar standard in order to deem a particular drug or biological to be identical or similar to another drug or biological for the purpose of limiting or reducing payment under Medicare. The amendment establishes that any current cost containment authority by the Secretary (such as the Inherent Reasonableness regulation or least costly alternative standard) is not affected.

Contact: Sarah Walter or Paige Jennings, 4-4623

51

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Breaux Amendment # 3

Short Title: **Physician Ownership and Self-Referral**

Current Law:
Section 1877 of the Social Security Act prohibits physician self-referrals – the referral of a patient for certain "designated health services" to an entity with which the physician (or immediate family member) has a financial interest. The statute creates a general prohibition on referrals, and then provides specific exceptions under which an otherwise prohibited referral may be made. Two of the exceptions permit a self-referral when the physician's ownership or investment interest is in a rural provider or a hospital. To qualify for the rural exception, the services must be provided in a rural area (as defined in section 1886 of the Medicare statute) and substantially all of the services must be provided to individuals residing in the rural area. To qualify for the hospital exception, the referring physician must be authorized to perform services at the hospital and the ownership or investment interest must be in the hospital itself (and not merely a subdivision of the hospital). This latter exception is referred to as the "whole hospital" exception.

Amendment Description:
- Sec. 1877(d)(3) would be amended to clarify the "whole hospital" exception to exclude those circumstances in which a physician's ownership interest is in a hospital that primarily or exclusively is devoted to cardiac, orthopedic, surgical, or other specialties designated by HHS regulation as inconsistent with the original intent of the law – that is, to allow physician ownership only where a comprehensive spectrum of inpatient and outpatient services are provided and the physician owners' specialty and self-referrals are insignificant in relation to the overall scope of services provided.
- Sec. 1877(d)(2) would be amended to clarify the "rural" exception to allow for physician ownership of designated health services only in those circumstances in which a rural community would not otherwise have access to services.

Contact: Sarah Walter or Paige Jennings, 4-4623

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AMENDMENT

to

The Prescription Drug and Medicare Improvement Act of 2003

Breaux Amendment # 4

Short Title: **Hospice Attending Physician Amendment**

Current Law:

Under current law, beneficiaries who elect the Medicare hospice benefit can continue to receive care from the "attending physician" who they identify as having the most significant role in the determination and delivery of medical care to them at the time they elect hospice. That physician, if he or she is not employed by the hospice program, can continue to bill and be paid for such care under Medicare Part B, just as they did prior to the patient electing hospice. However, the definition of "attending physician" in the hospice statute is limited to physicians, even though the Medicare program otherwise covers and pays for such "physician services" when they are provided by nurse practitioners ("NPs"), physician assistants ("PAs"), and clinical nurse specialists ("CNSs"), if they are acting within their scope of practice under relevant state law. Therefore, a patient whose primary healthcare provider is an NP, PA or CNS has to give up that relationship if they elect the hospice benefit, because that provider can no longer bill Medicare for services provided to their patients who are in hospice. This is particularly problematic in rural areas, where there is a shortage of physicians and patients are more likely to rely on these non-physician practitioners as their primary health care providers.

Amendment Description:

To amend the hospice provisions of the Social Security Act for the limited purpose of allowing an NP, PA, or CNS who is not employed by hospice to bill and be paid under Medicare Part B for otherwise covered "physician services" provided to a hospice patient who has identified the NP, PA or CNS as the health care provider having the most significant role in the determination and delivery of medical care to them.

This provision will make the Medicare program more consistent by allowing NPs, PAs and CNSs to provide covered care to beneficiaries whether or not they have elected the hospice benefit, and it will enhance continuity of care for patients by allowing them to continue to be seen by the health care provider who is most familiar with their medical history and condition, and who the patient has identified as being most involved with the patient's care.

Contact: Sarah Walter or Paige Jennings, 4-4623

53

AMENDMENT
to
Prescription Drug Medicare Improvement Act of 2003

Breaux/Grassley/Baucus Amendment # 5.

Short Title: Health Care Fraud and Abuse Control Account 2004-2005

Amendment Description: This amendment will increase the amount provided to the HHS/Office of Inspector General from the Health Care Fraud and Abuse Control Account by $10 million for fiscal year 2004 and by $20 million for fiscal year 2005.

Current Law:

From the U.S. Code Online via GPO Access
[wais.access.gpo.gov]
[Laws in effect as of January 23, 2000]
[Document not affected by Public Laws enacted between
January 23, 2000 and December 4, 2001]
[CITE: 42USC1395i]

TITLE 42--THE PUBLIC HEALTH AND WELFARE

CHAPTER 7--SOCIAL SECURITY

SUBCHAPTER XVIII--HEALTH INSURANCE FOR AGED AND DISABLED

Part A--Hospital Insurance Benefits for Aged and Disabled

Sec. 1395i. Federal Hospital Insurance Trust Fund

(k) Health Care Fraud and Abuse Control Account

(3) Appropriated amounts to Account for fraud and abuse control program, etc.

(A) Departments of Health and Human Services and Justice

(i) In general

There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to carry out the purposes described in subparagraph (C), to be available without further appropriation, in an amount not to exceed--
(I) for fiscal year 1997, $104,000,000,\1\

\1\ So in original. The comma probably should be a semicolon.

(II) for each of the fiscal years 1998 through 2003, the limit for the preceding fiscal year, increased by 15 percent; and

(III) for each fiscal year after fiscal year 2003, the limit for fiscal year 2003.

(ii) Medicare and medicaid activities

For each fiscal year, of the amount appropriated in clause (i), the following amounts shall be available only for the purposes of the activities of the Office of the Inspector General of the Department of Health and Human Services with respect to the Medicare and medicaid programs--

(I) for fiscal year 1997, not less than $60,000,000 and not more than $70,000,000;

(II) for fiscal year 1998, not less than $80,000,000 and not more than $90,000,000;

(III) for fiscal year 1999, not less than $90,000,000 and not more than $100,000,000;

(IV) for fiscal year 2000, not less than $110,000,000 and not more than $120,000,000;

(V) for fiscal year 2001, not less than $120,000,000 and not more than $130,000,000;

(VI) for fiscal year 2002, not less than $140,000,000 and not more than $150,000,000; and

(VII) for each fiscal year after fiscal year 2002, not less than $150,000,000 and not more than $160,000,000.

Suggested change:

Strike text of (k) ((3)(A)(i)(III) and replace with:

"(III) for fiscal year 2004 and thereafter, the limit for fiscal year 2003, plus an increase equivalent to the growth in Medicare program expenditures in addition to the amount for the preceding fiscal year."

Strike text of (k)((3)(A)(ii)(VII) and replace with:

"(VII) for fiscal year 2004, $170,000,000;

(VIII)for fiscal year 2005, $180,000,000.

Contact: Name & Phone Number: Sarah Walter 4-4623 or Lauren Fuller 4-1467

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AMENDMENT
to
Prescription Drug Medicare Improvement Act of 2003

Breaux/Grassley/Baucus Amendment # 6

Short Title: Health Care Fraud and Abuse Control Account 2005-2006

Amendment Description: This amendment will increase the amount provided to the HHS/Office of Inspector General from the Health Care Fraud and Abuse Control Account by $15 million for fiscal year 2005 and by $25 million for fiscal year 2006.

Current Law:

From the U.S. Code Online via GPO Access
[wais.access.gpo.gov]
[Laws in effect as of January 23, 2000]
[Document not affected by Public Laws enacted between January 23, 2000 and December 4, 2001]
[CITE: 42USC1395i]

TITLE 42--THE PUBLIC HEALTH AND WELFARE

CHAPTER 7--SOCIAL SECURITY

SUBCHAPTER XVIII--HEALTH INSURANCE FOR AGED AND DISABLED

Part A--Hospital Insurance Benefits for Aged and Disabled

Sec. 1395i. Federal Hospital Insurance Trust Fund

(k) Health Care Fraud and Abuse Control Account

(3) Appropriated amounts to Account for fraud and abuse control program, etc.

(A) Departments of Health and Human Services and Justice

(i) In general

There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to carry out the purposes described in subparagraph (C), to be available without further appropriation, in an amount not to exceed--
(I) for fiscal year 1997, $104,000,000,\1\

\1\ So in original. The comma probably should be a semicolon.

(II) for each of the fiscal years 1998 through 2003, the limit for the preceding fiscal year, increased by 15 percent; and

(III) for each fiscal year after fiscal year 2003, the limit for fiscal year 2003.

(ii) Medicare and medicaid activities

For each fiscal year, of the amount appropriated in clause (i), the following amounts shall be available only for the purposes of the activities of the Office of the Inspector General of the Department of Health and Human Services with respect to the Medicare and medicaid programs--

(I) for fiscal year 1997, not less than $60,000,000 and not more than $70,000,000;

(II) for fiscal year 1998, not less than $80,000,000 and not more than $90,000,000;

(III) for fiscal year 1999, not less than $90,000,000 and not more than $100,000,000;

(IV) for fiscal year 2000, not less than $110,000,000 and not more than $120,000,000;

(V) for fiscal year 2001, not less than $120,000,000 and not more than $130,000,000;

(VI) for fiscal year 2002, not less than $140,000,000 and not more than $150,000,000; and

(VII) for each fiscal year after fiscal year 2002, not less than $150,000,000 and not more than $160,000,000.

Suggested change:

Strike text of (k) ((3)(A)(i)(III) and replace with:

"(III) for fiscal year 2004 and thereafter, the limit for fiscal year 2003, plus an increase equivalent to the growth in Medicare program expenditures in addition to the amount for the preceding fiscal year."

Strike text of (k)((3)(A)(ii)(VII) and replace with:

"(VII) for fiscal year 2005, $175,000,000;

(VIII)for fiscal year 2006, $185,000,000.

Contact: Name & Phone Number: Sarah Walter 4-4623 or Lauren Fuller 4-1467

55

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Conrad Amendment # 1

Short Title: Access to a Stable Drug Benefit

Current Law
No provision

Amendment Description

This amendment would allow Medicare beneficiaries who are receiving drug coverage through a fallback plan to have the *choice* of permanently receiving coverage through this type of plan, even if in subsequent years two private, financial risk-bearing, drug-only plans enter the region in which the beneficiary resides. The underlying proposal would prohibit seniors from remaining in the fallback-type plan if more than two financial risk-bearing, drug-only plans enter an area, even if seniors like the fallback plan and do not want to switch to a different plan that has different benefits. This amendment would lift that restriction and ensure seniors are provided more stable benefit options.

Offset to be provided if necessary based on CBO score.

Contact: Neleen Eisinger, 4-7966

56

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Conrad Amendment # 2

Short Title: Same Contracting Cycle for Fallback Plans as Private Drug-only Plans

Current Law
No provision

Amendment Description

This amendment would require fallback plans to commit to a 2-year contract for serving a particular region, which would provide Medicare beneficiaries the assurance that they would be able to remain in a certain fallback plan for that time frame. The underlying proposal requires fallback plans to re-bid every year to serve a particular region. In contrast, financial risk-bearing, drug-only plans are *not* required to re-bid every year and are allowed to serve a region for a two-year contract. This amendment would bring the contract cycle for fallback plans in line with the longer contract required for drug-only private plans. The amendment would provide seniors a more stable drug benefit by offering them the *option* to remain in the fallback for a longer time period rather than forcing them to switch plans at the end of one year, even if they don't want to change.

Offset to be provided if necessary based on CBO score.

Contact: Neleen Eisinger, 4-7966

57

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Conrad Amendment # 3

Short Title: Reduce the Number of Times Seniors are Required to Switch Plans

Current Law
No provision

Amendment Description

In the underlying proposal, Medicare beneficiaries enrolled in the fallback plan would lose this coverage option if more than two, private, drug-only plans enter a region in a subsequent year. Because of these rules, there is *no limit* on how many times a senior could be enrolled in a fallback plan, required to leave if a drug-only plan enters the region, and then forced back into a fallback because the drug-only plan leaves the region again. This amendment would prohibit the Administrator from forcing Medicare beneficiaries out of a fallback plan and into a private plan more than one time throughout their lifetime. Specifically, the amendment would allow Medicare beneficiaries who are receiving drug coverage through a fallback plan and who meet certain conditions to have the *choice* of permanently receiving coverage through a fallback plan. The conditions would be that the beneficiary 1) had previously received coverage through a fallback plan, and 2) had been required to switch from the fallback plan in which he or she had previously been enrolled to a private drug-only plan because 2 or more private plans entered the region.

Offset to be provided if necessary based on CBO score.

Contact: Neleen Eisinger, 4-7966

58

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Conrad Amendment # 4

Short Title: Authorization for the Capital Infrastructure Loan Program

Current Law
No provision

Amendment Description

This amendment would authorize funding to establish a Capital Infrastructure Loan Program, which would be used to help rural health care facilities improve crumbling buildings and infrastructure and update technology. This amendment is based on a provision in the Health Care Access and Rural Equity Act (S. 816), which would make available $5m in loans for these facilities. In addition, rural providers could apply to receive $50,000 planning grants to help assess capital and infrastructure needs.

The amendment does not score.

Contact: Neleen Eisinger, 4-7966

59

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Conrad Amendment # 5

Short Title: Address Medicare Payment Inequities

Current Law
Current law allows the Administrator of CMS to reclassify hospitals for the purposes of the hospital inpatient wage index subject to certain geographic requirements, including mileage limitations.

Amendment Description
In rural states like North Dakota, the current law restriction produces unfair situations. Hospitals who are serving the same patients and competing to hire the same staff get paid different amounts based on outdated formulas, yet are not eligible for re-classification. This amendment would direct the Administrator of CMS to allow hospitals in the Bismarck, North Dakota, Metropolitan Statistical Area (MSA) to be re-classified for the purposes of the hospital inpatient wage index to the Fargo-Moorhead MSA.

The amendment would be budget neutral.

Contact: Neleen Eisinger, 4-7966

60

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Conrad Amendment # 6

Short Title: Stabilize Medicare Reimbursement for Providers of End Stage Renal Disease (ESRD) Care

Current Law
There is no update formula. However, the Chairman's mark specifies payment updates for 2004 and 2005.

Amendment Description

This amendment would direct the Administrator of CMS to establish and implement an annual payment update formula for ESRD services, based on the Medicare Dialysis Payment Fairness Act of 2003 (S. 1098). This would be effective January 1, 2006.

Offset: To be provided if needed based on CBO scoring.

Contact: Neleen Eisinger, 4-7966

61

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Conrad Amendment # 7

Short Title: Transitional Coverage of Certain Self-Injected Drugs

Current Law
Under current law, Medicare Part B covers certain drugs that must be administered in a physician's office. In some cases, there are similar drugs available to treat the same illness that could be self-injected at home; however, current law does not allow these to be covered.

Amendment Description

This amendment would direct the Administrator of CMS to provide immediate coverage under Medicare Part B for self-injected biologic drugs that are prescribed as replacements for physician-administered drugs already covered by Medicare. This transitional benefit would expire when a comprehensive Medicare drug benefit is implemented in 2006. This amendment would provide assistance to seniors and the disabled with serious chronic diseases, such as rheumatoid arthritis and multiple sclerosis, and would be particularly helpful for rural beneficiaries by allowing them to avoid traveling long distances to receive care in a physician's office.

Offset will be provided if necessary based on CBO score.

Contact: Neleen Eisinger, 4-7966

62

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Conrad Amendment # 8

Short Title: Cost-Effective and Quality Chronic Care Coordination for Medicare Beneficiaries in Traditional Medicare

Current Law
No provision

Amendment Description

The amendment would require the HHS Secretary to develop a demonstration program to provide care coordination services in the traditional fee-for-service program for Medicare beneficiaries with multiple chronic illnesses. Under this amendment, the Secretary would contract with a range of care management organizations to provide care coordination services to eligible beneficiaries. This program would be targeted to high-risk Medicare beneficiaries who have multiple chronic conditions, functional impairments, and are at risk of poor outcomes and high health care costs.

Under this structure, beneficiaries keep their existing physician and Medicare pays for standard services on a fee-for-service basis. A portion of the Medicare payments to care management organizations would be at risk for performance. The care management organization will be required to meet agreed-upon savings and outcomes targets in order to be paid the part of the fee that is at risk. All Medicare covered services for beneficiaries will continue to be paid on a fee-for-service basis by the Medicare fiscal intermediaries or carriers.

Care management organizations would include Medicare providers such as physicians, hospice providers, Medicare+Choice organizations, and beneficiary organizations. These organizations would provide a full range of care coordination services including: comprehensive health assessments, supportive services for physicians, care conferences, and ongoing coordination and monitoring.

Offset: The amendment is budget neutral.

Contact: Neleen Eisinger, 4-7966

63

AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003.

Graham Amendment # 1

Short Title: Repeal of Sick Tax

Amendment Description

No premium would be imposed on any beneficiary during periods while the beneficiary is in the "gap".

Contact: Lisa Layman/4-3041

64

AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003.

Graham Amendment # 2

Short Title: Providing a Medicare-guaranteed benefit to all rural beneficiaries

Amendment Description

The underlying mark provides a drug benefit through private drug-only insurance plans or managed care plans. The mark provides that if at least two private insurance plans do not emerge in an area of the country, the government would provide a drug benefit to the seniors in that area through the Medicare program. This amendment would make the Medicare-guaranteed standard benefit with a national premium available to all Medicare beneficiaries who do not reside within metropolitan statistical areas or who reside in metropolitan statistical areas with populations of 500,000 or less from the onset of the program.

Contact: Lisa Layman/4-3041

65

AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003.

Graham Amendment # 3

Short Title: Providing a Medicare-guaranteed comprehensive prescription drug benefit

Amendment Description

This amendment would guarantee access to affordable prescription drugs for all Medicare beneficiaries. The legislation would add fully-defined comprehensive coverage -- with no gaps or limits -- of prescription drugs to the Medicare benefits package beginning in 2006. Each beneficiary would know exactly what they would pay, and exactly what they would get:

- $25 monthly premium
- zero premium
- $10 deductible for generic drugs
- $40 copayment for medically necessary brand name drugs
- $4,000 cap on out-of-pocket expenditures
- Assistance begins with the very first prescription, and there would be no gaps or limits in the coverage.

Additional protections for beneficiaries with low-incomes: Medicare beneficiaries who are poor would receive their drug benefit through the Medicare program, as all Medicare beneficiaries would. Individuals below 160% of poverty would be protected against high drug expenditures without having to meet an assets test. These beneficiaries would be responsible for nominal co-payments. There would be no new costs to states.

The delivery structure would guarantee the drug benefit would be available in all parts of the country from the onset. Multiple private entities in each region would manage, deliver and administer the prescription drug benefit using the same methods they use in the private sector. The private entities would be held accountable for their performance in containing drug costs for beneficiaries and taxpayers, and for providing high quality care and high quality service.

Definitions, enrollment procedures, information requirements, establishment of premiums, minimum standards for eligible entities, payments to entities, provisions regarding employers, establishment of a Medicare Prescription Drug Advisory Committee, modifications to Medicare+Choice plans and Medigap plans, studies and reports and expansion of membership and duties of MedPAC would mirror those included in S. 2625 introduced in the 2nd session of the 107th Congress.

Contact Lisa Layman/4-3041

66

AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003.

Graham Amendment # 4

Short Title: Providing a Medicare-guaranteed comprehensive prescription drug benefit

Amendment Description

This amendment would guarantee access to affordable prescription drugs for all Medicare beneficiaries. The legislation would add fully-defined comprehensive coverage -- with no gaps or limits -- of prescription drugs to the Medicare benefits package beginning in 2006. Each beneficiary would know exactly what they would pay, and exactly what they would get:

- $25 monthly premium
- zero premium
- $10 deductible for generic drugs
- $40 copayment for medically necessary brand name drugs
- $4,000 cap on out-of-pocket expenditures
- Assistance begins with the very first prescription, and there would be no gaps or limits in the coverage.

Additional protections for beneficiaries with low-incomes: Medicare beneficiaries who are poor would receive their drug benefit through the Medicare program, as all Medicare beneficiaries would. Individuals below 150% of poverty would be protected against high drug expenditures without having to meet an assets test. These beneficiaries would be responsible for nominal co-payments. There would be no new costs to states.

The delivery structure would guarantee the drug benefit would be available in all parts of the country from the onset. Multiple private entities in each region would manage, deliver and administer the prescription drug benefit using the same methods they use in the private sector. The private entities would be held accountable for their performance in containing drug costs for beneficiaries and taxpayers, and for providing high quality care and high quality service.

Definitions, enrollment procedures, information requirements, establishment of premiums, minimum standards for eligible entities, payments to entities, provisions regarding employers, establishment of a Medicare Prescription Drug Advisory Committee, modifications to Medicare+Choice plans and Medigap plans, studies and reports and expansion of membership and duties of MedPAC would mirror those included in S. 2625 introduced in the 2nd session of the 107th Congress.

Contact Lisa Layman/4-3041

67

AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003.

Graham Amendment # 5

Short Title: Timely Implementation

Amendment Description

The benefit would be effective January 1, 2005.

Contact: Lisa Layman/4-3041

68

AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003.

Graham Amendment # 6

Short Title: Test to determine reliability of model

Amendment Description

The delivery of prescription drugs through the mechanisms in the mark would first be applied to all federal employees with incomes greater than $100,000. The drug benefit would be delivered through this means beginning January 1, 2004.

Contact: Lisa Layman/4-3041

69

AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003.

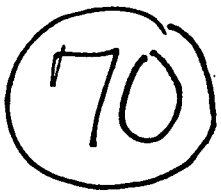
Graham Amendment # 7

Short Title: Test to determine reliability of model

Amendment Description

The delivery of prescription drugs through the mechanisms in the mark would first be applied to all federal employees with incomes greater than $100,000. The drug benefit would be delivered through this means beginning January 1, 2005.

Contact: Lisa Layman/4-3041



AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003.

Graham Amendment # 8

Short Title: Test to determine reliability of model

Amendment Description

The delivery of prescription drugs through the mechanisms in the mark would first be applied to all federal employees with incomes greater than $100,000. The drug benefit would be delivered through this means beginning January 1, 2006.

Contact: Lisa Layman/4-3041

71

AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003.

Graham Amendment # 9

Short Title: Short Title: Providing a Medicare-guaranteed benefit to all beneficiaries over the age of 75

Amendment Description

The underlying mark provides a drug benefit through private drug-only insurance plans or managed care plans. The mark provides that if at least two private insurance plans do not emerge in an area of the country, the government will provide a drug benefit to the seniors in that area through the Medicare program. This amendment would make the Medicare-guaranteed standard benefit with a national premium available to all Medicare beneficiaries over the age of 75.

Contact: Lisa Layman/4-3041

172

AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003.

Graham Amendment # 10

Short Title: Short Title: Providing a Medicare-guaranteed benefit to all beneficiaries over the age of 80

Amendment Description

The underlying mark provides a drug benefit through private drug-only insurance plans or managed care plans. The mark provides that if at least two private insurance plans do not emerge in an area of the country, the government will provide a drug benefit to the seniors in that area through the Medicare program. This amendment would make the Medicare-guaranteed standard benefit with a national premium available to all Medicare beneficiaries over the age of 80.

Contact: Lisa Layman/4-3041

73

AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003.

Graham Amendment # 11

Short Title: Short Title: Providing a Medicare-guaranteed benefit to all beneficiaries over the age of 85

Amendment Description

The underlying mark provides a drug benefit through private drug-only insurance plans or managed care plans. The mark provides that if at least two private insurance plans do not emerge in an area of the country, the government will provide a drug benefit to the seniors in that area through the Medicare program. This amendment would make the Medicare-guaranteed standard benefit with a national premium available to all Medicare beneficiaries over the age of 85.

Contact: Lisa Layman/4-3041

74

AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003.

Graham Amendment # 12

Short Title: Providing a Medicare-guaranteed benefit to all beneficiaries over the age of 90

Amendment Description

The underlying mark provides a drug benefit through private drug-only insurance plans or managed care plans. The mark provides that if at least two private insurance plans do not emerge in an area of the country, the government will provide a drug benefit to the seniors in that area through the Medicare program. This amendment would make the Medicare-guaranteed standard benefit with a national premium available to all Medicare beneficiaries over the age of 90.

Contact: Lisa Layman

75

AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003.

Graham Amendment # 13

Short Title: Providing a Medicare-guaranteed benefit to all beneficiaries over the age of 95

Amendment Description

The underlying mark provides a drug benefit through private drug-only insurance plans or managed care plans. The mark provides that if at least two private insurance plans do not emerge in an area of the country, the government will provide a drug benefit to the seniors in that area through the Medicare program. This amendment would make the Medicare-guaranteed standard benefit with a national premium available to all Medicare beneficiaries over the age of 95.

Contact: Lisa Layman/4-3041

76

AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003.

Graham Amendment # 14

Short Title: FEHBP BC/BS Standard Drug Benefit as Basis for Actuarial Equivalent Coverage

Amendment Description

Beneficiaries could purchase either "standard coverage" or actuarially equivalent coverage. In 2006, the actuarially equivalent coverage would be actuarially equivalent to the prescription drug coverage offered at that time under the FEHBP Blue Cross/Blue Shield standard option. The "standard coverage" would be modified to reflect a package actuarially equivalent to the FEHBP Blue Cross/Blue Shield standard option..

Contact: Lisa Layman/4-3041

77

AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003.

Graham Amendment # 15

Short Title: Limitation on Instability

Amendment Description

If a private plan exits a region it would only be allowed to return to that region once.

Contact: Lisa Layman/4-3041

78

AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003.

Graham Amendment # 16

Short Title: Information for Beneficiaries

Amendment Description

Beneficiaries must be provided with comparative plan information at least 30 days prior to any enrollment period. The information shall include a comparison of benefits provided under each plan offered by an eligible entity available to beneficiaries residing in an area. The information shall include a comparison of benefits provided under the plan including the prices beneficiaries will be charged for covered outpatient drugs, any preferred pharmacy networks used by the eligible entity under the plan, the formularies under the plan, premiums and cost-sharing.

Contact: Lisa Layman 224-3041

79

Amendment
to
The Prescription Drug and Medicare Improvement Act of 2003

Graham Amendment #17

Short Title: Provide adequate time frame for contracting

Amendment Description

Require Secretary to secure contracts with standard coverage plans and utilization risk plans by September 1, 2005.

Contact: Lisa Layman/4-3041

80

Amendment
to
The Prescription Drug and Medicare Improvement Act of 2003

Graham Amendment #18

Short Title: Beneficiary Information Provision

Amendment Description

Require Secretary to secure contracts with standard coverage plans and utilization risk plans by May 1, 2005.

Contact: Lisa Layman/4-3041

81

GRAHAM AMENDMENT # 19

to

THE PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

COMMITTEE ON FINANCE

Graham Amendment # 19

Short Title: The Immigrant Children's Health Improvement Act

One sentence description of Amendment: This amendment would give states the option to provide Medicaid and State Child Health Insurance Program (S-CHIP) coverage to lawfully present legal immigrant children and pregnant women.

Text of Amendment: The Graham amendment (S.845) would amend title IV (Restricting Welfare and Public Benefits for Aliens) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) to grant States the option of covering eligible women and child resident aliens under titles XIX (Medicaid) and XXI (Children's Health Insurance) (SCHIP) of the Social Security Act. This amendment would repeal the 5-year limitation on the eligibility of qualified aliens for federal Medicaid and SCHIP.

Contact: Jocelyn Moore, 202-224-1546

June 25, 2002

82

GRAHAM AMENDMENT # 20

to

THE PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

COMMITTEE ON FINANCE

Graham Amendment # 20

Short Title: The Immigrant Children's Health Improvement Act

One sentence description of Amendment: This amendment would give states the option to provide Medicaid and State Child Health Insurance Program (S-CHIP) coverage to lawfully present legal immigrant children and pregnant women. This amendment would also provide federal reimbursement of emergency health services furnished to undocumented aliens.

Contact: Jocelyn Moore, 202-224-1546

June 25, 2002

83

Amendment
to
The Prescription Drug and Medicare Improvement Act of 2003

Graham Amendment #~~1~~ 21

Short Title: Require Prescription Drug Benefit to be Defined.

Amendment Description

Amendment would require a defined benefit for utilization and performance risk plans, as follows:

$35 monthly premium
$275 Annual Deductible
50/50 cost-sharing above $275 in total drug spending to $3450 of total drug spending (or, whatever is specified in relation to the "gap" in the Modified Chairman's mark)
90% federal assistance on total drug spending over $5288.

Contact: Lisa Layman/4-3041

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act

84

Jeffords/Breaux Amendment # _1___

Short Title: _ REMOVING BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS BY CRITICAL ACCESS HOSPITAL FACILITIES

Amendment Description

Critical Access Hospitals (CAHs) are small, typically rural facilities that provide safety net services. Under current law they cannot exceed 25 patients at any given time with a maximum of 15 acute care inpatients and 10 "swing" patients. CAHs are prohibited from including either rehabilitation or psychiatric distinct part units. According to 1997 Medicare Cost Report Data, the hospitals most likely to serve as safety net facilities. defined as those with fewer than 25 or fewer beds of which 10 or less are utilized as psychiatric or rehabilitation beds, account for 7 of the most remote hospitals.

Under current practice this forces these facilities to reduce access to health care services in these remote communities or to drive up Medicare costs by forcing patients into 3-day hospital stays in lieu of shorter and less costly rehabilitation or psychiatric stays.

The amendment would provide the Secretary with authority to define either psychiatric or rehabilitation distinct part units of 10 or fewer beds for CAHs effective October 1, 2003.

Contact: Sean Donohue, 224-1283

Jim Jeffords

85.

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act

Jeffords Amendment # _2___

Short Title: Equitable Physician Services Adjustment

Amendment Description

Current Law

Medicare's payment for physicians' services under a fee schedule has three components: the relative value for the service, geographic adjustment factors and a conversion factor into a dollar amount. A service's relative value is made up of a physician work component, a practice expense component, and a malpractice expense component. Each of these is then adjusted by a separate geographic adjustment factor and combined together to calculate an indexed relative value for that service provided in a given location. This locality adjusted relative value unit is multiplied by the conversion factor to calculate Medicare's payment for a service provided by a physician in a given area.

The geographic adjustment factors are indices that reflect the relative cost difference in a given area in comparison to the national average. An area with costs above the national average would have an index greater than 1.00; alternatively, an area with costs below the national average would have an index less than 1.00. The physician work geographic adjustment factor is based on a sample of median hourly earnings in six professional specialty occupational categories.

Under the Chairman's Mark, services furnished after January 1, 2004. the Secretary would be required to increase the value of any work geographic index that is below .980 to .980. For services furnished after January 1, 2005,. The increase in expenditures resulting from the implementation of these floors would not be taken into account when applying the budget-neutrality requirement.

Explanation of Provision

This amendment would implement the Chairman's Mark provision 1 year earlier by requiring the Secretary, for services furnished after January 1, 2004, to increase the values for work, practice expense and malpractice geographic indices in low value localities areas would be raised to 1.00 until 2008.

Contact: Sean Donohue, 224-1283
Effective Date
Upon enactment.

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act

86

Jeffords Amendment # _3___

Short Title: Equitable Funding Adjustments for Home Health

Amendment Description

Current Law

Local hospital wage indexes is one of two key factors in determining how home health agencies are paid under Medicare. Wage indices in most geographic regions remain remarkably stable over time. However, abrupt changes can occur as a result of temporary, local economic factors that can result in wide negative fluctuations and subsequent reductions in reimbursements. Based on wage index rates published by CMS for FY 2003 resulted in a small number of instances or reductions in excess of 10 percent and one home health agency with a reduction of 18 percent.

As a result, these agencies are facing catastrophic, short term funding reductions preventing them from recruiting skilled staff and otherwise not meeting the needs of their patients. A short term solution is needed to mitigate the wide-wage index swings and subsequent precipitous changes in reimbursements.

Explanation of Provision

This amendment would provide that reimbursements for home health services occurring beginning in January 2004, reductions in the wage index portion of the reimbursement formula could not exceed 3 percent.

Effective Date

Upon enactment.

Contact: Sean Donohue, 224-1283

87

Bingaman Amendment # 1
To the Chairman's Medicare Mark

Reducing Negative Impact of Assets Test for Low-Income Beneficiaries

Purpose

To remove the assets test by which low-income Medicare beneficiaries qualify for certain low-income subsidies.

Explanation of Amendment

The amendment would reduce the negative impact that the assets test causes certain low-income Medicare beneficiares, which results in far higher cost sharing for low-income beneficiaries, by striking the assets test in the Chairman's mark.

Reason for Change

Under the bill, an assets test is imposed on low-income Medicare beneficiaries below 135% of poverty, which is just $12,372 for an individual and $16,608 for a couple. If an individual below this level of poverty has a savings bond of $4,100 or a car whose value exceeds that amount, their cost sharing substantially increases under the Chairman's Mark.

According to the Urban Institute, imposing an assets test would move the following individuals into much higher cost sharing levels:

Below 100% of poverty	26 percent of Medicare beneficiaries
101 – 135% of poverty	46 percent of Medicare beneficiaries

Those below 100% of poverty, would have their cost-sharing increased by over 400% if they exceed the assets test of just $4,000 for an individual and $6,000 for a couple. This potentially creates incentives for chronically ill, low-income seniors and disabled to further impoverish themselves to qualify for reduced cost sharing or face substantially higher cost sharing.

88

Bingaman Amendment # 2
To Chairman's Medicare Mark

Reducing the Impact on Out-of-Pocket Cost Sharing for Low-Income Beneficiaries due to Assets Test

Purpose:

To improve the protection for low-income beneficiaries, including many with extremely low-incomes who are disqualified from more assistance because of the asset test, from high out-of-pocket Rx costs.

Explanation of Amendment:

Strike 20% cost-sharing and substitute 10% cost-sharing for costs above the initial coverage limit and below the annual catastrophic limit.

Reason for Change:

A person can be classified into the 135-160% assistance category even though their income might be, for example, $5000, but they fail to meet the asset test because they disqualify for SSI and QMBy (etc.) with a $4,100 savings bond. If this person were one of the 10.2% of Medicare beneficiaries with more than $5,000 in prescription drug expense, the co-payments required in the 135-160% category would still consume about 14% of their incredibly limited income.

Any step to help reduce these somewhat rare but catastrophic burdens would be an important health care improvement.

Cost estimate:

There are 3.9 million people below 135% of poverty who are disqualified from help because of the asset test, and who are placed in the 135-160% category. There are about 4.8 million people in the 135-160% income range. A total of 8.7 million people would be potentially impacted. About 10% of these will have Rx expenditures that place them in the donut. Moving the co-pay in the donut from 20% to 10% will save them an average of $100. Total cost per year would be about $87 million, or about $450 million over five.

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Bingaman Amendment # 3
To the Chairman's Mark

Outreach and Enrollment for Low-Income Assistance Program

Purpose: -

To ensure effective outreach and enrollment of eligible beneficiaries in the prescription drug low-income assistance program.

Explanation of Amendment:

In addition to outreach information and enrollment assistance to eligible low-income beneficiaries at State Medicaid and at Social Security offices, the Secretary shall undertake a program of information, outreach, appropriate mailings, and enrollment assistance with appropriate state agencies and through appropriate Federal agencies. Outreach and assistance activities will be conducted at low-income assistance sites, including but not limited to, Federal, State, and local low-income housing, energy, nutrition, health, and social service sites. Special efforts shall be made to outreach to disadvantaged and rural populations and other hard-to-reach populations. The Secretary shall reimburse other agencies for their appropriate expenses in this program.

Eligibility forms shall be as simple as possible and shall be for 24 months with automatic renewal, although beneficiaries would be required to report disqualifying income and asset increases to the Secretary.

Mail-in and electronic filings should be permitted (face-to-face interviews should not be required). Beneficiaries should be able to simply fill out and mail in applications.

Reason for Change:

Current low-income assistance programs (such as the QMBy, SLMBy, and QI-1 programs) fail to enroll many eligible beneficiaries. History has shown that enrollment through state Medicaid offices is not effective in reaching many eligibles. The Chairman's mark allows Social Security offices to participate in outreach and enrollment, but more aggressive and creative outreach is needed.

The amendment simply ensures that those who are eligible for the program actually enroll in it, if they desire.

90

Bingaman Amendment # 4
To the Chairman's Medicare Mark

Two-Year Contracting by All Health Plans in Medicare

Purpose

To provide for increased stability to low-income seniors and disabled in the Medicare program.

Explanation of Amendment

All drug plans and Medicare Advantage plans would be required to sign two-year contracts. Timing for bidding and other requirements in the Mark would all be adjusted to comply with two-year contracts.

Reason for Change

The bill creates dramatic volatility with health plans and drug plans all having one-year contracts so that beneficiaries may have to change medical providers and drug plans on an annual basis. There is substantial research that indicates that continuity of care is important to quality of care and leads to reduced medical errors and morbidity.

Plan and provider stability are also important to Medicare beneficiaries.

91

Bingaman Amendment # 5
To Chairman's Medicare Mark

Providing Consumer Protections in Health Plans

Purpose:

To improve consumer protections and reduce the ability of health plans to charge higher cost-sharing than fee-for-service for certain services or drugs in order to discourage enrollment by beneficiaries with certain chronic conditions.

Explanation of Amendment:

The legislation would improve consumer protections to Medicare beneficiaries seeking to enroll in Medicare Advantage and private drug plans by prohibiting private drug plans or Medicare Advantage plans from charging higher cost-sharing for a service than Medicare charges in the fee-for-service program.

Reason for Change:

Under current law, cost sharing per enrollee (including premiums) for covered services cannot be more than the actuarial value of the deductibles, coinsurance, and copayments under traditional Medicare fee-for-service. In the Chairman's mark, this provision is extended to private drug plans offered to delivery the fee-for-service drug benefit.

However, there are a number of studies and testimony before the House Ways and Means Committee indicating that Medicare+Choice plans are increasingly charging higher cost-sharing for individual services within the health plan than is allowed in fee-for-service. Higher cost-sharing, for example, is being required by some Medicare+Choice plans for dialysis, hospitalization, and other services than in traditional fee-for-service Medicare.

In addition to creating an adverse consequence for the health of Medicare beneficiaries with disabilities who have certain illnesses, charging beneficiaries higher costs for certain services results in what is referred to as "cherry picking," as some plans seek to avoid or deny services to the chronically or serverely ill. Again, this can have adverse health effects for certain beneficiaries, limit their choices, and result in higher costs for the Medicare payment through "risk selection."

Consequently, this amendment would close this loophole and prohibit private drug plans and Medicare Advantage plans from imposing higher cost sharing for certain services than is allowed in Medicare fee-for-service.

92

Bingaman Amendment # 6
To Chairman's Medicare Mark

Consumer Education and Counseling

Purpose

To build on existing ombudsmen, advice, and counseling programs in the States and to provide more adequate, dependable funding of these consumer services.

Explanation of Amendment

Insert after section 534 a subsection to provide reliable, more adequate funding of existing state health insurance ombudsmen, advice, and counseling services. The Secretary would transfer $1 per Medicare Part A, B, or C enrollee into a Consumer Ombudsman account. This account would be authorized to be appropriated for purposes of funding the State Health Insurance Program counseling programs established by section 4360 of OBRA 1990.

Reason for Change

There is going to be tremendous confusion and uncertainty among Medicare beneficiaries and their families about these new options, about the new Rx plans, the new PPOs, and the new names and administrative divisions within Medicare.

There will be a desperate need to help educate and assist beneficiaries with all the new options. It is important to provide a reliable funding sources for such education, counseling, and assistance. Given the difficult problems facing the discretionary appropriations accounts, it is important to provide a reliable, dependable formula for funding these efforts out of the Trust Funds. There is precedent from a similar program in the BBA to educate seniors about the M+C choices.

There is a small CMS beneficiary ombudsman office provided in the House-passed bill (HR 810, section 303, which CBO estimated [see the Ways and Means Committee report H.Rept. 108-74, Part 1] would require about $6 million a year). That provision is not nearly enough, given the tremendous changes about to occur. In addition, there is no need to set up a new ombudsman counseling program: there is already an extensive system of State Health Insurance Assistance Programs (SHIPs) that provides education, counseling, and assistance. This program is annually funded at about $12 million (less than 35 cents per beneficiary) in HHS/CMS appropriations under section 4359 and 4360 of the Omnibus Budget Reconciliation Act of 1990. It is run by the states or by state non-profit contractors, and is substantially staffed by volunteers.

Cost: Approximately $41 million a year from Part A, minus the saving of $12 million appropriated annually to SHIPs equals an annual net cost of $29 million or approximately $150 million over five years.

93

Bingaman Amendment # 7
To Chairman's Medicare Mark

Establish New Medigap Wrap-Around Options

Purpose:

To allow seniors in FFS to buy a supplemental benefit package that could be offered in Medigap plans

Explanation of Amendment:

The amendment would require the Secretary to establish new Medigap options to allow seniors to purchase Medigap coverage to wrap-around the prescription drug benefit in this package and other gaps in Medicare coverage.

Reason for Change:

The Chairman's mark eliminates those plans that provide limited prescription drug coverage. Rather than eliminating them, the amendment would require the Secretary to establish new Medigap options that would wrap around the benefit provided in this bill.

Medicare beneficiaries should not be prevented from purchasing coverage that protects their often limited, monthly income from unexpectedly high prescription drug or other Medicare out-of-pocket costs.

94

Bingaman Amendment # 8
To the Chairman's Medicare Mark

Protecting Medicare Disproportionate Share Hospital (DSH) Payments To Safety Net Hospitals

Purpose

To remove Medicare disproportionate share hospital (DSH) payment from calculation of Medicare managed care capitation payments and ensure that these payments are received by the hospitals for whom DSH payments are intended.

Explanation of Amendment

The Amendment would carve out Medicare DSH payments from the payments to Medicare+Choice plans and the new Preferred Provider Organizations (PPO) by creating a new subparagraph in Section 1853(c)(3) of the Social Security Act, which deals with calculation of capitation rates for Medicare managed care entities, to ensure that the amounts estimated by the Secretary to be attributable to Medicare DSH are excluded and carved out from the capitation rates and paid back disproportionate share hospitals.

This change would conform treatment of Medicare DSH with the treatment of medical education, which is already excluded from the managed care capitation rate calculation and to the Medicaid DSH program.

Reason for Change

Under the prospective payment system (PPS), the Medicare program makes special adjustments in payments to hospitals that treat large volumes of low-income patients. This payment adjustment, called a disproportionate share hospital (DSH) payment, is intended to assist hospitals in maintaining access to care for low-income Medicare beneficiaries. For each Medicare beneficiary, Medicare makes an additional add-on payment beyond the base price of the case to safety net hospitals.

Estimates of growth in Medicare+Choice or PPO enrollment range from 2% additional enrollment by the Congressional Budget Office this past weekend to over 30% according to testimony by Tom Scully with the Centers for Medicare and Medicaid Services (CMS) at the Finance hearing last Friday. The calculation of the capitation rate includes the DSH payments. Therefore, as more people sign up for PPOs and Medicare+Choice plans, safety net hospitals will lose DSH payments through reduced FFS payments and the funding will instead by to PPOs and Medicare+Choice plans.

In order to make sure that teaching hospitals receive graduate medical education (GME) payments intended to reimburse hospitals for training costs, there is a carve-out of GME payments from the calculation of managed care capitation rates and the payment is made directly

to teaching payments when they care for a Medicare HMO patient. The same rationale applies to DSH payments.

DSH payments should be paid directly to hospitals to make sure that those funds are used to maintain access to care for low-income Medicare beneficiaries in hospitals that treat a large volume of low-income patients. Current law already carves out DSH payments from Medicaid payments to managed care organizations.

With a carve-out and direct payment to safety net hospitals, these payments will reduce or dissipate in the system if more and more Medicare beneficiaries joint managed care entites as a result of the incentives created by this legislation.

In its March 1998 report to the Congress, the Medicare Payment Advisory Commission (MedPAC) recommended carving DSH payments out of the rates Medicare pays to Medicare+Choice health plans and making them directly to DSH hospitals. MedPAC states that "plans are overpaid to the extend that they do not pass on DSH payments to the appropriate hospitals."

Estimated Cost

The amendment is budget neutral. The amendment does not increase payments by the Medicare program, but merely redirects payments already made by the Medicare program or to be made by the Medicare program.

95

Bingaman Amendment # 9
To Chairman's Medicare Mark

Wrap-Around Payments to Federally Qualified Health Centers (FQHCs)

Purpose:

The amendment would establish a supplemental or "wrap-around" payment requirement much like the one that currently exists in the Medicaid program for FQHCs contracting with Medicare Advantage health plans.

Explanation of Amendment:

In 1990, Congress extended reasonable cost payments to FQHCs under traditional Medicare (Part B), in order to protect the integrity of the PHS Act grant funds received by health centers to provide care to the uninsured. By extending this requirement to Medicare Advantage, the amendment affirms Congress' commitment to expanding access to services under Medicare while also protecting access to care for health centers' uninsured patients. Under Medicaid law, a health center is reimbursed by a health plan (MCO) equivalent to what the MCO pays any other provider of similar services. In turn, the State Medicaid program makes a "wrap-around" payment for the difference between the MCO's payment and the health center's reasonable costs. Because this program has worked exceedingly well in Medicaid, Congress should also enact a "wrap-around" payment in the Medicare Advantage managed care program.

Reason for Change:

Without the amendment, health centers will be reimbursed at significantly less that their reasonable costs for care provided to Medicare Advantage enrollees, forcing them to make up those losses by using federal grant funds intended to support care for the uninsured, since they are not permitted to limit care for their Medicare patients.

Cost Estimate:

Unavailable (NOTE: Total Medicare payments to FQHCs in 2002 was $260 million, or .1% [one-tenth of one percent] of all Medicare spending; FQHCs currently receive reasonable cost reimbursement for all care provided to their nearly 1 million Medicare patients, except for the 2% who are Medicare+Choice enrollees).

96

Bingaman Amendment # 10
To the Chairman's Medicare Mark

Medicare Incentive Payment Program Improvements

Purpose

To make the 10% bonus increase provided by Congress to physicians in health professional shortage areas (HPSAs) to receive the payment automatically.

Explanation of Amendment

The language would come from the "Medicare Incentive Payment Program (MIPP) Improvement Act" and included in the Senate Rural Health Caucus package as well. The language would make these payments automatic rather than requiring physicians to even know about this payment, go through the bureaucratic process of applying for it, and subjecting themselves to increased audits for having applied.

The underlying Chairman's mark has language on the issue as well and this amendment just clarifies the language comes from the legislative language in S. 379.

97

Bingaman Amendment # 11
To the Chairman's Medicare Mark

State Carrier Medical Directors (CMD) in Every State

Purpose

To ensure Medicare carriers maintain utilization of at least one full-time physician Carrier Medical Director (CMD) in each State, or reasonable geographic area.

Explanation of Amendment

This language is virtually identical to that within S. 3018, the "Beneficiary Access to Care and Medicare Equity Act of 2002," introduced by Senators Baucus and Grassley and cosponsored by a number of bipartisan senators on the Finance Committee. The language would simply require Medicare carriers to maintain at least one full-time physician CMD in each state, or reasonable geographic area.

Reason for Change

Physician access to a CMD is essential as carriers develop local coverage policies that affect beneficiaries. The physician community often catches oversights and makes suggestions for improving the draft local policies, identifying the diagnoses for which Medicare will pay for a particular service. The ability to receive and incorporate local physician input will be compromised if there is no physician CMD. The result will be more denials for beneficiaries and more out-of-pocket costs.

Furthermore, physician access to a CMD is integral as CMS increases its emphasis on educating physicians regarding Medicare rules. The February 2002 United States General Accounting Office (GAO) report "Communications With Physicians Can Be Improved" documented the alarming frequency by which carrier customer service personnel provide inaccurate and incomplete information to physicians. Physicians rely on a CMD as a definitive source of information.

98

Bingaman Amendment # 12
To the Chairman's Medicare Mark

Dental Residencies in Medicare GME

Purpose

To clarify that the 3-year rolling average in calculating Medicare graduate medical education (GME) payments, which was intended to alleviate the impact on hospitals that decrease physician GME slots, does not impact dental residency positions that are not capped.

Explanation of Amendment

The amendment exempts dental residency training programs from (1) the three year "rolling average" provision used to calculate the number of full-time-equivalent (FTE) residents for Medicare GME reimburseent, and (2) the one-year intern-resident to bed ratio lag in IME payments.

Reason for Change

Exempting dental positions from the "rolling average" and one-year IRB lag provisions is consistent with the previous Congressional decision to ensure that Medicare GME policy does not place a cap or limit the number of dental residency positions. Unlike medicine, there are not enough dental residency positions for dental school graduates. In 1997-98, first year accredited postdoctoral dental residency positions would have accommodated only 64 percent of all U.S. dental school graduates.

The Institute of Medicine (IOM), in its 1995 study on dental education, recommended that there be an increase in the number of primary care dental residencies to accommodate all graduates of U.S. dental schools seeking such training. Many dental education institutions are attempting to expand their primary care (general dentistry and pediatric dentistry) residency programs. The 1997 IOM report on establishing a national GME trust fund acknowledged concerns about subjecting dental residency positions to mandated reductions based on physician over-supply.

99

Bingaman Amendment # 13
To the Chairman's Medicare Mark

Clarification Of Requirements for Counting Residents in Non-Hospital Settings for Medicare GME

Purpose

To clarify Congressional intent and existing policy in making graduate medical education (GME) payments that, in order to include resident time training in a non-hospital setting, the hospital must incur all, or substantially all, the costs of the program in that site.

Explanation of Amendment

This language would clarify Congressional intent in the Balanced Budget Act (BBA) of 1997 with respect to providing GME support to hospitals that incur the cost of resident training programs in non-hospital settings. The BBA changes have enhanced training opportunities and experiences in these non-traditional locations and provided urgently needed health care to underserved patient populations.

The amendment would clarify that to receive GME payments for resident training in non-hospital locations, the hospital must incur all, or substantially all, the costs of the training in that site from the effective date of a written agreement between the hospital and the entity owning and operating the non-hospital site, which are often community health centers or rural health clinics, and not from the inception of the program. The legislative language defines "all or substantially all" the costs of the non-hospital site as the residents' stipends and benefits and other costs, if any, as determined by the contract.

Reason for Change

Despite long-standing policy since 1997 on this issue and the significant strides in resident training and expanded patient care that the BBA has made in non-traditional settings, a proposed rule issued by the Centers for Medicare and Medicaid Services (CMS) in the May 19, 2003 *Federal Register*, would unreasonably require hospitals to have incurred the costs at these non-hospital sites since the very inception of the training program at that location. If the site had ever received, for example, a private foundation grant, the proposed rule would effectively deny GME payments for residents training at that site at any time.

As a result, the amendment is supported by the Association of American Medical Colleges (AAMC), American Dental Education Association, American Dental Association, American Association for Dental Research, American Academy of Pediatric Dentistry, Society of Teachers of Family Medicine, Association of Departments of Family Medicine, Association of Family Practice Residency Directors, and the North American Primary Care Research Group.

Estimated Cost

The amendment clarifies current policy prior to the enactment of the proposed rule so should have no cost.

100

Bingaman Amendment # 14
To the Chairman's Medicare Mark

Indian Medicare Technical Amendments

Purpose

To correct problems within the Medicare program with respect to providing reimbursement for the full range of Medicare benefits delivered at Indian hospitals and clinics and ensure that the Indian Health Service (IHS), which is chronically underfunded, no longer subsidizes the Medicare program.

Explanation of Amendment

The proposed amendment would achieve the following objectives:

- Makes IHS hospitals and clinics eligible for reimbursements for all medical and other health services, items and devices covered by Medicare Part B to the same extent that any other hospital or clinic in the nation is eligible. In short, the amendment eliminates those items that IHS facilities currently cannot bill for under Medicare Part B.

  This includes: durable medical equipment, home and some institutional dialysis supplies and equipment; prostate-specific blood tests and pap smears; glaucoma screening; clinic or hospital-based ambulance services; prosthetic devices; covered vaccines; chemotherapy and antigen drugs; and, clinical laboratory services.

- Requires Medicare providers to charge no more than Medicare rates for inpatient hospital services provided to Indians who are eligible for contract health services from the Indian Health Service, tribally-operated health programs, and urban Indian organizations. This is similar to language regarding contract health services purchased by the Veterans Administration and the Department of Defense.

- Creates a uniform payment methodology available to IHS and tribal clinics and corrects the current situation where payment rates differ widely – based not on the nature of the services a clinic provides, but on whether the facility is operated by the IHS or operated by a tribe, and whether the clinic is considered provider-based or free-standing.

Reason for Change

Medicare payments to IHS facilities and tribal health organizations has not been updated for years. The current system provides Medicare payment to IHS facilities and clinics for only certain Part B services, based mostly on whether the Congress remembered to allow IHS facilities to be reimbursed for those services when Congress added the benefit to Medicare, such as pap smears, immunizations, etc.

The amendment also allows IHS to maximize its purchase of contract health services, just as is done by the Veterans Administration and the Department of Defense. Since the contract health services account is chronically under-funded, IHS and the tribes seriously ration and often exhaust those funds before the end of the fiscal year. In FY 2001 alone, the Indian Health Service had insufficient funding to provide services for over 100,000 cases that met its medical priority criteria and denied 22,000 other cases of medically necessary care which did not meet IHS medical priorities. Therefore, this amendment would enable IHS and tribes to achieve greater economy for the provision of contract health services.

The Department of Health and Human Services Office of Inspector General's Cost-Saver Handbook has annually made this recommendation. As per its 2003 *Red Book* or cost-saver handbook reads, "As a federal purchaser of inpatient health care from the private sector, IHS should receive rates commensurate with those received by other federal agencies that engage in similar purchases [such as the VA and DOD]." The Inspector General adds, "If the favorable Medicare rates were legislatively required, the dollars saved could be applied to the backlog of patient services that cannot be accommodated in the Contract Health Services program."

The amendment also rationalizes a payment system to Indian clinics by allowing all Indian clinics to collect reimbursements at the IHS/CMS all-inclusive rate, which is the same method by which IHS-funded clinics are reimbursed for Medicaid services.

101

Bingaman Amendment # 15
To the Chairman's Medicare Mark

Indian Contract Health Services and Medicare Payments

Purpose

To correct problems within the Medicare program with respect to providing reimbursement for the full range of Medicare benefits delivered at Indian hospitals and clinics and ensure that the Indian Health Service (IHS), which is chronically underfunded, no longer subsidizes the Medicare program.

Explanation of Amendment

The amendment requires Medicare providers to charge no more than Medicare rates for inpatient hospital services provided to Indians who are eligible for contract health services from the Indian Health Service, tribally-operated health programs, and urban Indian organizations. This is similar to language regarding contract health services purchased by the Veterans Administration and the Department of Defense.

Reason for Change

The amendment allows IHS to maximize its purchase of contract health services, just as is done by the Veterans Administration and the Department of Defense. Since the contract health services account is chronically under-funded, IHS and the tribes seriously ration and often exhaust those funds before the end of the fiscal year. In FY 2001 alone, the Indian Health Service had insufficient funding to provide services for over 100,000 cases that met its medical priority criteria and denied 22,000 other cases of medically necessary care which did not meet IHS medical priorities. Therefore, this amendment would enable IHS and tribes to achieve greater economy for the provision of contract health services.

The Department of Health and Human Services Office of Inspector General's Cost-Saver Handbook has annually made this recommendation. As per its 2003 *Red Book* or cost-saver handbook reads, "As a federal purchaser of inpatient health care from the private sector, IHS should receive rates commensurate with those received by other federal agencies that engage in similar purchases [such as the VA and DOD]." The Inspector General adds, "If the favorable Medicare rates were legislatively required, the dollars saved could be applied to the backlog of patient services that cannot be accommodated in the Contract Health Services program."

102

Bingaman Amendment # 16
To the Chairman's Medicare Mark

Requiring Guaranteed Drug Option to Native Americans

Purpose

To provide for increased stability and realistic drug plan options for Native Americans in the Medicare program.

Explanation of Amendment

Native Americans would be provided a guaranteed and standard drug benefit on an annual basis.

Reason for Change

American Indian and Alaska Native (AI/AN) Medicare beneficiaries should not be required to enroll in a non-Indian plan or HMO to receive better benefits. Health plans are seldom accessible in Indian Country, and culturally-competent private health plans rarely, if ever, exist.

103

Bingaman Amendment # 17
To Chairman's Medicare Mark

Eliminating Overpayments to Medicare Advantage Plans and Improve the Medicare Drug Benefit

Purpose:

To eliminate overpayments to Medicare Advantage Plans and improve the Medicare drug benefit.

Explanation of Amendment:

The amendment would limit Medicare Advantage payments to HMOs and PPOs to no more than the fee-for-service rate. Savings from this provision would be plowed back into the prescription drug benefit and go 50% to reducing the premium for prescription drugs and 50% to reducing the coverage gap in the proposal.

Reason for Change:

Medicare+Choice plans are already paid higher payments than fee-for-service. As the HHS Office of the Inspector General (OIG) reports, "Based on numerous OIG reviews, studies by other agencies, and MCO data, we concluded that MCOs receive morethan an adequate amount of funds to deliver the Medicare package of covered services." These payments above the level paid by fee-for-service is confirmed by the Congressional Budget Office and the Medicare Payment Advisory Commission (MedPAC).

The Preferred Provider Organizations (PPOs), in the Chairman's mark, are paid on a formula that pays the average of the higher of fee-for-service payments or Medicare+Choice payments.

In surveys of Medicare beneficiaries, they most object to premiums above $25 per month and the coverage gap, as proposed in this package. The amendment seeks to improve the drug benefit in both areas as much as is allowed by the offset.

104

Bingaman Amendment # 18
To Chairman's Medicare Mark

Eliminating Overpayments to Medicare Advantage Plans and Address the Physician Payment Shortfall

Purpose:

To eliminate overpayments to Medicare Advantage Plans and address problems with the Medicare physician payment formula.

Explanation of Amendment:

The amendment would limit Medicare Advantage payments to HMOs and PPOs to no more than the fee-for-service rate. Savings from this provision would be plowed back into the physician payment rate.

Reason for Change:

Medicare+Choice plans are already paid higher payments than fee-for-service. As the HHS Office of the Inspector General (OIG) reports, "Based on numerous OIG reviews, studies by other agencies, and MCO data, we concluded that MCOs receive morethan an adequate amount of funds to deliver the Medicare package of covered services." These payments above the level paid by fee-for-service is confirmed by the Congressional Budget Office and the Medicare Payment Advisory Commission (MedPAC).

The Preferred Provider Organizations (PPOs), in the Chairman's mark, are paid on a formula that pays the average of the higher of fee-for-service payments or Medicare+Choice payments.

Problems with the Medicare physician payment formula will result in an estimated 4.4% reduction in physician payments in 2004.

The amendment therefore addresses overpayments to private plans and seeks to address the problem with the physician payment formula to the extend allowed by the offset.

105

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Kerry Amendment # 1

Short Title: **Eliminating the Coverage Gaps**

Amendment Description:

The Medicare Prescription Drug benefit included in the Chairman's mark contains large gaps in coverage for seniors that reach the upper limits of prescription drug coinsurance but have not yet qualified for catastrophic coverage protections. This amendment would eliminate the coverage gaps, or "doughnut." Offset to be determined.

Contact: Heather Mizeur 4-4030

106

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Kerry Amendment # 2

Short Title: **Medigap to Fill the Gap**

Amendment Description:

This amendment would restore seniors' current option of buying Medigap supplemental insurance to fill in important gaps in Medicare's benefits – in this case, the gap created by the new Medicare prescription drug proposals. The Chairman's mark would prohibit the sale of Medigap insurance to fill in the prescription drug cost sharing of the new Part D benefit. This means that the one in four Medicare beneficiaries who have high enough drug spending to hit the "gap" in coverage must pay the full costs of prescription drugs out their limited income or savings, unless they are one of the few with retiree health coverage. The current option of purchasing Medigap insurance to fill in Medicare cost sharing would be banned under the proposal. However, the plan does allow private preferred provider organizations and HMOs to fill in the gap in prescription drug coverage. This means that seniors would be forced to join private plans to have any relief from the "gap".

This amendment would provide Medicare beneficiaries with the option of staying in traditional Medicare and purchasing supplemental Medigap coverage for prescription drugs. It prevents them from being forced to go into private plans to get relief from the high cost of coverage after the Medicare benefit stops and before the stop-loss begins. It would require the Secretary to work with the National Association of Insurance Commissioners to develop a new Medigap option that would reduce cost sharing in a reasonable way.

Contact: Heather Mizeur 4-4030

107

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Kerry Amendment # 3

Short Title: **Protecting Employer Coverage**

Amendment Description:

The Chairman's mark does not count payments made on the beneficiaries' behalf by entities other than the beneficiary towards reaching the stop-loss. As a result, CBO assumes that about one-third of all people with employer coverage will lose their employer drug benefits once Medicare Part D is implemented. This amendment would change the definition of true out of pocket costs to count any employer contributions to drug costs made on the beneficiaries' behalf toward the catastrophic limit. Offset to be determined.

Contact: Heather Mizeur 4-4030

108

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Kerry Amendment # 4

Short Title: **Improving the Discount Card for Low-Income Beneficiaries**

Amendment Description:

The Chairman's mark would provide access to low-income beneficiaries, through a discount card, to up to $150 per calendar quarter for prescription drug costs. This amendment would allow the full year's funding of $600 to be available from the first quarter on, and to allow any balances on the card to carry over into year two.

Contact: Heather Mizeur 4-4030

109

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Kerry Amendment # 5

Short Title: **Administrative Improvements**

Amendment Description:

This amendment would make two changes to improve the administrative structure of the underlying bill. The first change would be to require the same percent limits on administrative costs of any participating health plan in Medicare as OPM requires for plans participating under FEHBP. The second change would be to strike the provisions that establish the Center for Medicare Choices as a separate agency and instead require that the new agency division remain under the Center for Medicare and Medicaid Services.

Contact: Heather Mizeur 4-4030

110

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Kerry Amendment # 6

Short Title: **Fairness for Urban Hospitals**

Amendment Description:

The Chairman's mark includes numerous provisions to make much-needed changes in reimbursement policies for rural providers. However, urban teaching hospitals and safety net hospitals need relief as well – and a one-year fix in the Medicaid DSH Cliff contained in the bill is a wonderful first step. Two additional provisions addressed by this amendment are a 2-year fix for Medicare IME and an adjustment for Pickle DSH hospitals.

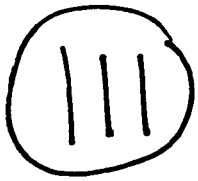
Amendment on Medicare IME:
This amendment would restore IME to 6.5% for 2 years at an estimated cost of $1.45 billion. This restoration will impact more than one quarter of the nation's hospitals, including at least one in every state.

Amendment on Pickle DSH:
This amendment would increase the Pickle DSH operating payment adjustment from 35% to 40%. This will be the first increase in the past 12 years. The provision also includes language that extends that payment level to capital payments, i.e. the capital adjustment for Pickle DSH hospitals will increase from approximately 12% to 40%.

This same Pickle DSH fix was included in last year's provider giveback bill sponsored by Baucus and Grassley (S 3018). Since the number of qualifying hospitals is so small, CBO is expected to give this proposal a low score.

Offset for both to be determined.

Contact: Heather Mizeur 4-4030



AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Kerry Amendment # 7

Short Title: **Mental Health Copay Equity Act**

Amendment Description:

This amendment would adopt the language of S. 853, the "Medicare Mental Health Copay Equity Act." Currently, Medicare discriminates against patients seeking outpatient treatment for mental illness by requiring them to pay 50% of the cost of their care out of pocket. This amendment would require such patients to pay only the same 20% coinsurance required for all other Medicare Part B services by phasing the rate down over six years.

This amendment has been endorsed by 56 national organizations in the "Mental Health Liaison Group." An independent analysis by PriceWatherhouseCoopers estimates the 10 year cost to be slightly over $5 billion. Offsets to be determined later.

Contact: Heather Mizeur 4-4030

112

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Kerry Amendment # 8

Short Title: **Medicare Vision Rehabilitation Services Act**

Amendment Description:

This amendment would adopt the language of S. 1095, the "Medicare Vision Rehabilitation Services Act," which provides Medicare coverage for vision rehabilitation services to help senior who are blind or partially sighted.

113

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Kerry Amendment # 9

Short Title: **Beneficiary Cost-Sharing Protections**

Amendment Description:

This amendment will protect seniors from increased Medicare cost sharing imposed under the Chairman's mark by striking the provisions in the bill that index the Part B premiums to inflation and by striking the provisions in the bill that impose a new coinsurance requirement on beneficiaries for clinical laboratory services.

Contact: Heather Mizeur 4-4030

114

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Kerry Amendment # 10

Short Title: **Equity for Puerto Rico**

Amendment Description:

The Chairman's mark does not include Puerto Rico equitably in the prescription drug proposals. Instead, the bill creates a $20 million set-aside for Puerto Rico. The set-aside has no foundation in either health care or economic policy. It creates a wider gap in the quality and accessibility of health care between the mainland and the Island. Puerto Rico has been included in Medicare since the program's origins, yet under this bill the Island would be treated differently.

This amendment would require Puerto Rico to be included in the Medicare prescription drug benefit as well as the interim discount card.

Contact: Heather Mizeur 4-4030

115

AMENDMENT

to

The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment # 1

Short Title: Better Discounts for Seniors

Amendment Description

This amendment strikes Section 1807 (Medicare Prescription Drug Discount Card Endorsement Program) and replaces it with a provision allowing the Secretary of HHS to offer Medicare beneficiaries the discounted rate in the Federal Supply Schedule (FSS), ensuring the discount comes out of the manufacturer and not the pharmacist.

Medicare beneficiaries would achieve much deeper discounts from the FSS than from negotiated rates obtained by any private entities.

Contact: Elizabeth MacDonald 224-4730

116

AMENDMENT

to

The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment # 2

Short Title: Better Discounts for Seniors

Amendment Description

This amendment strikes Section 1807 (Medicare Prescription Drug Discount Card Endorsement Program) and replaces it with a provision allowing the Secretary of HHS to offer Medicare beneficiaries the Medicaid Best Price, ensuring the discount comes out of the manufacturer and not the pharmacist.

Medicare beneficiaries would achieve much deeper discounts from the Medicaid Best Price than from negotiated rates obtained by any private entities. The Medicaid price is at least 25 percent lower than the retail price many Medicare beneficiaries now pay for their medicines.

Prescription drug costs are rising at a rate of 13 percent annually, and almost 40 percent of seniors nationwide have no prescription drug coverage. Medicare beneficiaries without drug coverage fill 50 fewer prescriptions and face out-of-pocket drug costs that are 40 percent higher than those who have drug coverage. Seniors and others without prescription drug coverage need help now.

Contact: Elizabeth MacDonald 224-4730

117

AMENDMENT

to

The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment # 3

Short Title: Providing a Medicare-guaranteed benefit to all beneficiaries

Amendment Description

The underlying mark provides a drug benefit through private drug-only insurance plans or managed care plans. If a private insurance plan does not emerge in an area of the country, the government will provide a drug benefit to the seniors in that area through the Medicare program. This amendment would make the Medicare-guaranteed benefit available to all Medicare beneficiaries for at least 2 years. Offset to be determined.

Contact: Elizabeth MacDonald 224-4730

AMENDMENT

to

The Prescription Drug and Medicare Improvement Act of 2003

118

Lincoln Amendment # 4

Short Title: Providing a Medicare-guaranteed benefit to all beneficiaries

Amendment Description

The underlying mark provides a drug benefit through private drug-only insurance plans or managed care plans. If a private insurance plan does not emerge in an area of the country, the government will provide a drug benefit to the seniors in that area through the Medicare program. This amendment would make the Medicare-guaranteed benefit available to all Medicare beneficiaries for at least 3 years. Offset to be determined.

Contact: Elizabeth MacDonald 224-4730

119

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment # 5

Short Title: To provide for a national Medicare Prescription Drug Plan Premium

Amendment Description:

This amendment amends Section 1860D-16, Payments to Eligible Entities, to add the requirement that payments to plans be geographically adjusted in a budget-neutral manner to account for differences in utilization across service areas.

Contact: Elizabeth MacDonald, 224-4730

120

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment # 6

Short Title: Ensure Maximum Enrollment in low-income assistance programs

Amendment Description:

To ensure maximum enrollment in low-income assistance programs, the Secretary of HHS may conduct outreach through the following:

1. Social Security Administration Offices
2. State Medicaid offices
3. all other programs where Federal and state low-income assistance is provided, including (but not limited to) energy, housing, nutrition, Community Health Centers, State Health Insurance Assistance Programs, and social service agencies

In addition, the Secretary is encouraged to 1) conduct special outreach efforts in historically underserved populations, 2) make eligibility determination forms and paperwork as simple as possible, with mail-in or electronic filings possible and no required face-to-face interviews, 3) make eligibility determination for as long as possible, ideally once, with the obligation on the beneficiary to report changes (increases) in income and assets, and 4) to report to Congress, within three years, on best practices in the successful enrollment of low-income beneficiaries, and shall rank the States on their relative success in enrolling eligibles.

Offset to be determined.

Contact: Elizabeth MacDonald, 224-4730

121

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment # 7

Short Title: Help Neediest Seniors

Amendment Description:

In the current "non-dual and others below 160% FPL with no asset test," lower the coinsurance from 20% to 10% for drug spending between $3,451 and the stoploss limit. Offset to be determined.

Contact: Elizabeth MacDonald, 224-4730

122

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment # 8

Short Title: Help Neediest Seniors

Amendment Description:

1) Go up to 175% of poverty in current "non-dual and others below 160% FPL with no asset test." Adjust the sliding premium accordingly. Lower the coinsurance for this level (7.5% coinsurance for drug spending to benefit gap of $3,450 instead of 10%, and 15% coinsurance for drug spending between $3,451 and the stoploss limit instead of 20%)

2) To ensure maximum enrollment in low-income assistance programs, the Secretary of HHS may conduct outreach through the following:

1. Social Security Administration Offices
2. State Medicaid offices
3. all other programs where Federal and state low-income assistance is provided, including (but not limited to) energy, housing, nutrition, Community Health Centers, State Health Insurance Assistance Programs, and social service agencies

In addition, the Secretary is encouraged to 1) conduct special outreach efforts in historically underserved populations, 2) make eligibility determination forms and paperwork as simple as possible, with mail-in or electronic filings possible and no required face-to-face interviews, 3) make eligibility determination for as long as possible, ideally once, with the obligation on the beneficiary to report changes (increases) in income and assets, and 4) to report to Congress, within three years, on best practices in the successful enrollment of low-income beneficiaries, and shall rank the States on their relative success in enrolling eligibles.

Offset to be determined.

Contact: Elizabeth MacDonald, 224-4730

123

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment # 9

Short Title: Help Neediest Seniors

Amendment Description:

1) Go up to 200% of poverty in current "non-dual and others below 160% FPL with no asset test." Adjust the sliding premium accordingly. Lower the coinsurance for this level (7.5% coinsurance for drug spending to benefit gap of $3,450 instead of 10%, and 15% coinsurance for drug spending between $3,451 and the stoploss limit instead of 20%)

2) To ensure maximum enrollment in low-income assistance programs, the Secretary of HHS may conduct outreach through the following:

1. Social Security Administration Offices
2. State Medicaid offices
3. all other programs where Federal and state low-income assistance is provided, including (but not limited to) energy, housing, nutrition, Community Health Centers, State Health Insurance Assistance Programs, and social service agencies

In addition, the Secretary is encouraged to 1) conduct special outreach efforts in historically underserved populations, 2) make eligibility determination forms and paperwork as simple as possible, with mail-in or electronic filings possible and no required face-to-face interviews, 3) make eligibility determination for as long as possible, ideally once, with the obligation on the beneficiary to report changes (increases) in income and assets, and 4) to report to Congress, within three years, on best practices in the successful enrollment of low-income beneficiaries, and shall rank the States on their relative success in enrolling eligibles.

Offset to be determined.

Contact: Elizabeth MacDonald, 224-4730

124

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment #10

Short Title: Sense of the Senate that Congress should alleviate the negative impact of the $1,500 therapy cap

Amendment Description

The amendment expresses the sense of the Senate that Congress should take action this year to alleviate the negative impact the $1,500 cap on outpatient physical therapy, occupational therapy, and speech-language pathology services will have on Medicare beneficiaries.

The $1,500 therapy cap is as much of a problem in 2003, as it was in 1997 when it was originally passed by Congress in an effort to find savings to balance the federal budget. Today, Congress is caught in the middle of a policy it acknowledges is unfair and the high cost of eliminating that policy once and for all. Repeal of the cap is estimated to cost $6.3 billion over 10 years.

Congress has taken action in the past to deny enforcement of the therapy cap, as was done in 1999 and 2000. The cost of extending the moratorium for two additional years is approximately $1 billion. The most recent moratorium expired on January 1, 2003. While the Center for Medicare and Medicaid Services was not prepared to enforce the cap at that time, it has indicated the therapy cap will be enforced as of July 1, 2003.

Clearly, the $1,500 cap discriminates against the frailest of Medicare beneficiaries. While the majority of beneficiaries will not exceed an annual $1,500 limit on services, it would force approximately 13% of the seniors and individuals with disabilities to pay for such services out-of-pocket, as noted in a report commissioned by Congress. Beneficiaries who suffer from a stroke, hip fracture or have Parkinson's and other conditions that require extensive rehabilitation are most likely to be affected by this short-sided Medicare policy.

This amendment has no cost.

Contact: Elizabeth MacDonald, 224-4730

125

AMENDMENT

to

The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment # 11

Short Title: Adult Day Services Health Care Options for Home Health Beneficiaries

Amendment Description:

This amendment would provide beneficiaries new choices, make Medicare more flexible, and increase Medicare competition by giving Medicare home health users the option to receive some or all of current Medicare home health benefits in an adult day group setting. Qualified medical adult day providers would be required to meet the same Medicare conditions of participation and quality standards as current home health providers, and would be paid 95% of what home health providers would have been paid for the same patient. Participating adult day providers would also be required to provide medication management, supervised activities, and meals without additional compensation. No changes to current law on Medicare eligibility or services covered. To further ensure budget neutrality, the Secretary could adjust the payment percentage downward if utilization is higher than projected.

Budget Neutral.

Contact: Elizabeth MacDonald, 224-4730

126

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment #12

Short Title: Physical Therapy Direct Access Demonstration

Amendment Description:

This amendment will establish a budget neutral demonstration project to determine the merits of allowing beneficiaries direct access to physical therapists' services within the Medicare program, as authorized by State law.

The project shall be conducted for a period of 3 years and include sites in at least 5 States. Evaluations shall focus on the impact of the project on program costs to the Medicare program and patient satisfaction with health care services. It shall include comparisons, with respect to episodes of care involving direct access to physical therapy services and episodes of care involving a physician referral for such services, including the average number of claims paid per episode for outpatient physical therapy services, the average number of physician office visits per episode; and the average expenditures per episode. Effective upon enactment.

Currently, some thirty-seven (37) states allow direct access to physical therapist services. While non-Medicare patients can directly access such services in these states, Medicare beneficiaries are restricted from such access by the requirement that they obtain a referral from another practitioner. Requiring a referral is unnecessary and limits access to timely and medically necessary physical therapists' services.

The referral requirement to access physical therapists can cause delays and denials of services provided by physical therapists. Delays in care result in higher cost, decreased functional outcomes, and frustration for patients. Direct access to physical therapists improves the accessibility of rehabilitation services.

Cost: Budget neutral. The Secretary would have the authority to terminate the operation of the project before the end of the 3-year period if the Secretary determines, based on actual data, that the total amount expended for all services over a 12-month period are greater than the total amount that would have been expended for such services but for the operation of the project.

Contact: Elizabeth MacDonald, 224-4730

127

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment #13

Short Title: Geriatrics GME

Amendment Description:

Under current law, hospitals receive 100% direct and indirect GME reimbursement for an initial residency period not to exceed 5 years for an individual. 42 U.S.C. 1395ww(h)(5)(F)(i); 42 U.S.C. 1395ww(h)(4)(C). Following this period, hospitals receive funding for only 50% of the direct training costs for an individual. A statutory exception, however, allows hospitals to receive an additional two years of 100% funding for training geriatric and preventive medicine residents or fellows. 42 U.S.C. 1395ww(h)(5)(F)(ii).

The implementing regulations further define the geriatric exception. The regulation states that geriatric medicine residency programs that qualify for the exception must be approved programs. 42 C.F.R. 413.86(g)(1)(iii). Approved geriatric programs are fellowship programs of one or more years in length that are approved by the Accreditation Council for Graduate Medical Education (ACGME) and the appropriate certifying entities (American Board of Internal Medicine/American Board of Family Physicians). 42 C.F.R. 413.86(a)(3).

The definition of an approved program follows, **If the ACGME . . decreases the minimum number of years of formal training necessary to satisfy the requirements for a specialty . . . the Secretary may decrease the period of board eligibility for that specialty, but not below the period of board eligibility.** 42 U.S.C. 1395ww(h)(5)(G)(iii)(II).

This provision would clarify that geriatric training programs are eligible for two years of fellowship support under direct and indirect GME, as provided for currently under the Social Security Act.

Reason for Change

In 1998, the American Board of Internal Medicine and the American Board of Family Physicians altered the minimum training requirement for eligibility for certification in geriatrics from 2 to 1 year. While this change increases the ability of training programs to produce clinical geriatricians, it was not intended to reduce support for training of teachers and researchers in geriatrics, which is still also desperately needed. Graduates of two-year fellowships provide critical geriatrics training to the primary care and specialty physicians who will deliver the vast majority of care for the nation's older population.

Since this change in 1999, the number of 2nd year geriatrics' fellows has decreased dramatically, from 222 in the year 1999 – 2000 to 88 in the year 2001- 2002. In the year

2001- 2002, 2nd year geriatrics' fellowship slots were filled at almost a 100% rate.

This change will help to maintain incentives for fellows to continue into 2nd year training. 2nd year training is a critical pathway to careers in academics and research. Without this change, there will continue to be a decline in the number of people willing to enter the 2nd year of fellowship. As the well-documented geriatrician shortage worsens, 2nd year training is increasingly important as a means of educating non-geriatrician primary care providers to serve the frail elderly population.

Estimated Cost over 10 year costs are $57 million. Senator Lincoln would like to work with the Chairman and Ranking Member to find an offset.

Contact: Elizabeth MacDonald, 224-4730

128

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment #14

Short Title: Chronic Care Management

Amendment Description:
This amendment seeks to improve the Medicare system in a narrow, targeted fashion, by establishing a limited, flexible care coordination fee-for-service (FFS) benefit. The amendment builds on important lessons learned in the private sector though disease management programs and managed care practices.

The amendment would require the HHS Secretary to establish eligibility criteria for the care management benefit that would target approximately 5% of elderly Medicare fee-for-service enrollees. The eligibility criteria should identify enrollees *who need care management* because they have multiple chronic conditions that result in high use of Medicare services, high use of prescription medications, and high Medicare costs. Inability to manage one's own care due to cognitive impairment should be considered as an additional indicator of need for care management.

Chronic Condition: Chronic conditions are defined as, "an illness, functional limitation, or cognitive impairment that is expected to last at least one year, limits what a person can do, and requires ongoing care."

Eligible Physician Provider: A Medicare-participating physician provider or independent nurse practitioner as defined in the Social Security Act who is approved by the Secretary and has at least 50 eligible beneficiaries in her practice.

Other details available upon request.

Sunset: The new program would sunset 5 years after program implementation.

Estimated Cost: $2 billion/10 years (not official CBO score)

Offset
Under FEHBP, profits for private plans are limited to 1.5%. This amendment would apply this standard in this mark to offset this proposal. Otherwise, Senator Lincoln would like to work with the Chairman and Ranking Member to find an offset.

Contact: Elizabeth MacDonald, 224-4730

129

AMENDMENT
to
The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment #15

Short Title: Insulin Syringe Coverage

Amendment Description:

This amendment ensures coverage for "syringes for the administration of insulin, and necessary medical supplies associated with the administration of insulin as determined and defined by the Secretary of HHS." Currently, Medicare Part B does not cover insulin or syringes to inject insulin. It is unclear whether insulin syringes are covered in this mark.

Approximately 7 million Americans over 65 have diabetes today. About 4.6 million seniors are diagnosed with diabetes while the remaining number does not know that they have the disease. Roughly 40% of the senior population with diabetes, or 1.8 million seniors, injects insulin to control their diabetes every day. Providing coverage for insulin syringes will go a long way towards helping seniors who take insulin to keep their diabetes in control. Syringe coverage will also help senior Americans manage or prevent long-term complications of diabetes like kidney failure, blindness, and amputations by helping to keep blood glucose levels in a normal range.

The lack of guaranteed coverage for syringes by Medicare drug plans means that syringe purchases will not count towards co-payments and yearly maximum out-of-pocket expenses. This lack of coverage could lead towards beneficiaries using syringes that are not FDA approved for more than one use.

The missing insulin syringe coverage is especially troublesome for Medicaid beneficiaries who will likely lose coverage for syringes that they currently have under their Medicaid plan.

Offset to be determined.

Contact: Elizabeth MacDonald, 224-4730

130

AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment #16

Short Title: Access to Diabetes Screening Services

Amendment Description:
Amends title XVIII (Medicare) of the Social Security Act (SSA) to provide for coverage of diabetes screening tests and services. Identical to S. 599 (Lincoln/Collins)

This amendment will help to bring the epidemic of diabetes under control by providing Medicare coverage for laboratory diagnostic tests and other services which are used to screen for diabetes. Medicare cannot currently provide these screening services because they are prohibited to do so by federal law.

Recently, the National Institutes of Health, the CDC and the American Diabetes Association announced that the direct costs of treating diabetes grew by more than 50 percent between 1997 and 2002, from $44 billion to $91.8 billion. One of every ten dollars spent on healthcare in America is now spent on diabetes, and the average per capita cost of healthcare for a person living with diabetes is $13,243 versus $2,560 for a typical American without diabetes.

The Centers for Disease Control, National Institutes of Health, and the Department of Health and Human Services recently joined together in a national education campaign to inform people about diabetes and encourage people age 45 and older to get screened for diabetes.

Unfortunately, current law does not allow Medicare to reimburse for diabetes testing, even if a patient presents serious risk factors for diabetes such as obesity, high blood pressure, or high cholesterol. Most shockingly, even if a patient is experiencing early evidence of diabetes complications, such as blindness or kidney disease, Medicare still cannot reimburse a physician for diabetes testing.

Our nation is not yet doing enough to manage this preventable and controllable disease. Screening can identify the disease, even before any symptoms have appeared, and has the potential to save and improve thousands of lives. In addition, this screening will potentially help prevent countless cases of end-stage renal disease, blindness and amputations – preventable complications of the diabetes that are draining Medicare of vital resources.

Offset to be determined.

Contact: Elizabeth MacDonald 224-4730

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AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment #17
Short Title: Providing improved access to osteoporosis testing
Amendment Description

This amendment will eliminate cost-sharing under Medicare for bone mass measurements. It would make the Federal payment 100 percent. This amendment is identical to S. 1113. (Lincoln/DeWine) Offset to be determined.

Contact: Elizabeth MacDonald 224-4730

132

AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment # 18
Short Title: Providing coverage for kidney disease education services
Amendment Description

This amendment would provide coverage for kidney disease education services furnished upon the managing physician's referral to an individual with kidney disease who will require dialysis or a kidney transplant. It would require that these education services include comprehensive information regarding management, prevention and options for treatment of kidney disease, and to ensure that such individuals have the opportunity to participate actively in the choice of therapy. It is identical to S. 1114. (Lincoln/Collins) Offset to be determined.

Contact: Elizabeth MacDonald 224-4730

133

AMENDMENT
to

The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment #19
Short Title: Providing coverage of marriage and family therapist services and mental health counselor services
Amendment Description

This amendment would provide coverage of marriage and family therapist services and mental health counselor services under Medicare Part B. It would include coverage of certain mental health services provided in rural health clinics and federally qualified health centers and certain marriage and family therapist services provided in hospices. It is identical to S. 310. (Lincoln/Thomas) Offset to be determined.

Contact: Elizabeth MacDonald 224-4730

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AMENDMENT

to

The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment #20

Short Title: Medicare Coverage of Routine Costs Associated with Certain Clinical Trials

Amendment Description

Medicare pays for the routine costs of FDA-approved clinical trials (both drugs and devices) - - except for a small number of approved breakthrough device trials. Despite a 2000 announcement that CMS would implement a presidential executive order to provide reimbursement for the routine costs of care for breakthrough technologies, the policy has not been implemented. This delay is impeding development of potentially life-saving technologies, like heart assist devices, for Medicare patients in need of new treatment options.

The amendment would direct CMS to keep its commitment to cover the routine costs of clinical trials of breakthrough medical technologies. This policy would have a minimal impact on Medicare spending (breakthroughs represent only six percent of FDA-approved studies) but a huge impact on Medicare patients awaiting emerging breakthroughs like implantable artificial hearts, bioartificial livers and kidneys and "bionic eyes" to treat blindness."

The amendment would require the Secretary to deem FDA-approved clinical trials as automatically qualified for coverage of routine costs associated with such clinical trials. Nothing in this Section shall be construed as authorizing or requiring the Secretary to modify the current policy with respect to coverage of, or payment for, a medical device subject to a clinical trial subject of an FDA IDE exemption.

At the appropriate place in the bill, insert the following:

SEC. ___. MEDICARE COVERAGE OF ROUTINE COSTS ASSOCIATED WITH CERTAIN CLINICAL TRIALS. (a) IN GENERAL- With respect to the coverage of routine costs of care for beneficiaries participating in a qualifying clinical trial, as set forth on the date of the enactment of this Act in National Coverage Determination 30-1 of the Medicare Coverage Issues Manual, the Secretary shall deem clinical trials conducted in accordance with an investigational device exemption approved under section 520(g) of the Federal Food, Drug, and Cosmetic Act (42 U.S.C. 360j(g)) to be automatically qualified for such coverage.

(b) RULE OF CONSTRUCTION- Nothing in this section shall be construed as authorizing or requiring the Secretary to modify the regulations set forth on the date of the enactment of this Act at subpart B of part 405 of title 42, Code of Federal Regulations, or subpart A of part 411 of such title, relating to coverage of, and payment for, a medical device that is the subject of an investigational device exemption by the Food and Drug Administration (except as may be necessary to implement subsection (a)).

(c) EFFECTIVE DATE- This section shall apply to clinical trials begun before, on, or after the date of the enactment of this Act and to items and services furnished on or after such date.

Contact: Elizabeth MacDonald 224-4730

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AMENDMENT

to

The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment # 21

Short Title: Physician Ownership and Self-Referral

Amendment Description

Congress has long sought to control conflicts of interest when a physician is making a clinical judgment about a patient's need for medical services. These concerns are heightened when the physician refers a patient to obtain services from a provider in which the physician or a member of their family has a financial or ownership interest. Specifically, the fear is that physicians with financial interests in the referral of a patient to a service or an entity may do so for unneeded services in order to increase their income. With the marked increase in physician-owned specialty care entities, there is a need to revisit the provisions that control such conflicts of interest to ensure that they appropriately reflect today's environment.

Current Law

Section 1877 of the Social Security Act prohibits physician self-referrals – the referral of a patient for certain "designated health services" to an entity with which the physician (or immediate family member) has a financial interest. The statute creates a general prohibition on referrals, and then provides specific exceptions under which an otherwise prohibited referral may be made. Two of the exceptions permit a self-referral when the physician's ownership or investment interest is in a rural provider or a hospital. To qualify for the rural exception, the services must be provided in a rural area (as defined in section 1886 of the Medicare statute) and substantially all of the services must be provided to individuals residing in the rural area. To qualify for the hospital exception, the referring physician must be authorized to perform services at the hospital and the ownership or investment interest must be in the hospital itself (and not merely a subdivision of the hospital). This latter exception is referred to as the "whole hospital" exception.

Proposed Changes

- Sec. 1877(d)(3) would be amended to clarify the "whole hospital" exception to exclude those circumstances in which a physician's ownership interest is in a hospital that primarily or exclusively is devoted to cardiac, orthopedic, surgical, or other specialties designated by HHS regulation as inconsistent with the original intent of the law – that is, to allow physician ownership only where a comprehensive spectrum of inpatient and outpatient services are provided and the physician owners' specialty and self-referrals are insignificant in relation to the overall scope of services provided.

- Sec. 1877(d)(2) would be amended to clarify the "rural" exception to allow for physician ownership of designated health services only in those circumstances in which a rural community would not otherwise have access to services.

Budget Neutral

Contact: Elizabeth MacDonald 224-4730

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AMENDMENT

to

The Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment # 22

Short Title: Medicare Ambulance Payment Reform

Amendment Description

This amendment would strike the 5%, 3-year rural increase proposed in the current package and replace it with 3 years of the provisions described in S. 171, which is detailed below.

The approximate total cost of the amendment would be 1.23 billion over the three-year period. Senator Lincoln would like to work with the Chairman and Ranking Member on an offset.

S. 171

AMBULANCE PAYMENT RATES

(a) PAYMENT RATES-

(1) IN GENERAL- Section 1834(l)(3) of the Social Security Act (42 U.S.C. 1395m(l)(3)) is amended to read as follows:

`(3) PAYMENT RATES-

(A) IN GENERAL- Subject to any adjustment under subparagraph (B) and paragraph (9) and the full payment of a national mileage rate pursuant to paragraph (2)(E), in establishing such fee schedule, the following rules shall apply:

`(i) Payment rates in 2003-

`(I) GROUND AMBULANCE SERVICES- In the case of ground ambulance services furnished under this part in 2003, the Secretary shall set the payment rates under the fee schedule for such services at a rate based on the average costs (as determined by the Secretary on the basis of the most recent and reliable information available) incurred by full cost ambulance suppliers in providing nonemergency basic life support ambulance services covered under this title, with adjustments to the rates for other ground ambulance service levels to be determined based on the rule established under paragraph (1). For the purposes of the preceding sentence, the term `full cost ambulance supplier' means a supplier for which volunteers or other unpaid staff comprise less than 20 percent of the supplier's total staff and which receives less than 20 percent of space and other capital assets free of charge.

`(II) OTHER AMBULANCE SERVICES- In the case of ambulance services not described in subclause (I) that are furnished under this part in 2003, the Secretary shall set the payment rates under the fee schedule for such services based on the rule established under paragraph (1).

`(ii) PAYMENT RATES IN SUBSEQUENT YEARS FOR ALL AMBULANCE SERVICES- In the case of any ambulance service furnished under this part in 2004 through 2006, the Secretary shall set the payment rates under the fee schedule for such service at amounts equal to the payment rate under the fee schedule for that service furnished during the previous year, increased by the percentage increase in the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year.

`(B) ADJUSTMENT IN RURAL RATES- For years beginning with 2004, the Secretary, after taking into consideration the recommendations contained in the report submitted under section 221(b)(3) the Medicare, Medicaid, and SCHIP Benefits Improvements and Protection Act of 2000, shall adjust the fee schedule payment rates that would otherwise apply under this subsection for ambulance services provided in low density rural areas based on the increased cost (if any) of providing such services in such areas.'.

(2) CONFORMING AMENDMENT- Section 221(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement

and Protection Act of 2000 (114 Stat. 2763A-487), as enacted into law by section 1(a)(6) of Public Law 106-554, is repealed.

(b) USE OF MEDICAL CONDITIONS FOR CODING AMBULANCE SERVICES- Section 1834(l)(7) of the Social Security Act (42 U.S.C. 1395m(l)(7)) is amended to read as follows:

`(7) CODING SYSTEM-

`(A) IN GENERAL- The Secretary shall, in accordance with section 1173(c)(1)(B), establish a system or systems for the coding of claims for ambulance services for which payment is made under this subsection, including a code set specifying the medical condition of the individual who is transported and the level of service that is appropriate for the transportation of an individual with that medical condition.

`(B) MEDICAL CONDITIONS- The code set established under subparagraph (A) shall--

`(i) take into account the list of medical conditions developed in the course of the negotiated rulemaking process conducted under paragraph (1); and

`(ii) notwithstanding any other provision of law, be adopted as a standard code set under section 1173(c).'.

SEC. 3 EFFECTIVE DATE

(a) These amendments shall be in effect beginning January 1, 2004 through December 31, 2006.

Contact: Elizabeth MacDonald 224-4730

137

AMENDMENT
to
Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment # 23

Short Title: Tricare Access Improvement Amendment

Amendment Description:

Amendment to waive the late enrollment penalty for military retirees and their spouses who sign up for Medicare Part B between January 1, 2001 and December 31, 2004. The amendment would also permit year-round enrollment through 2004 so that retirees can access the new benefits immediately. Currently, individuals who do not join Medicare Part B when initially eligible can only do so during the annual open enrollment season, which runs from January 1 until March 31.

The Defense Authorization Act of 2000 extended TRICARE eligibility to military retirees over 65 and provided them with a new pharmacy benefit. To participate in TRICARE-for-Life, retirees must be enrolled in Medicare Part B, a voluntary program that covers physician services, outpatient hospital care, and ancillary services.

Under current law, persons who do not enroll in Medicare Part B when first eligible must pay a 10% penalty for every year they have not participated. The Department of Defense now estimates that 84,000 military retirees would be subject to the penalties.

CBO cost is $10 million per year; $100 million over 10 years. Offset to be determined.

Contact: Jim Stowers 224-0549

138

AMENDMENT
to
Prescription Drug and Medicare Improvement Act of 2003

Lincoln Amendment # 24

Short Title: Expanding the Work of Medicare Quality Improvement Organizations in the New Medicare System

Amendment Description:

The statute for the Medicare Quality Improvement Organizations (QIOs) should be amended to include the new sections of Medicare that create the Medicare Advantage Plans, the Medicare Prescription Drug Plans and the Prescription Drug Assistance Cards.

The QIOs currently have responsibility for beneficiary protection and clinical quality improvement in all other parts of Medicare. They have strict federal confidentiality requirements that allow them access to patient identifiable information in medical records, Part A and B claims data, and information from M+C organizations. They are currently charged with helping to improve care in hospitals, physicians' offices, nursing homes and home health agencies. Access to basic outpatient prescription drug claims data and the authority to work with Medicare Advantage plans would complete their ability to help improve the quality of care for Medicare beneficiaries across the entire continuum of the care.

The Secretary should be able to instruct the QIOs to make their assistance available to providers, practitioners, benefit administrators and plans (on a voluntary basis) to improve the quality of care under the new Medicare system. It would be consistent with the structure Congress built originally, with QIOs able to work to ensure high quality delivery of items and services offered under FFS Medicare, as well as benefits received from HMOs/CMPs under section 1876. This extension of their work, and access to data from all parts of the system, will help make sure that there is continuity of care in the Medicare system. This will become particularly important as patients not only move from the inpatient to outpatient settings – but also exercise their new ability to move between FFS, and several different PPOs.

The work of the QIOs is a general beneficiary protection for all Medicare beneficiaries and should be included in this bill.

There should not be a cost.

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