Prescription Drug Coverage for Medicare Beneficiaries: A Side-by-Side Comparison of S. 1 and H.R. 1

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for The Henry J. Kaiser Family Foundation

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PRESCRIPTION DRUG PROPOSALS IN THE 108th CONGRESS

	S. 1 as amended and passed in Senate June 27, 2003	H.R. 1 as amended and passed in House of Representatives June 27, 2003
Title of Bill	Prescription Drug and Medicare Improvement Act of 2003	Medicare Prescription Drug and Modernization Act of 2003
General Approach	Voluntary stand-alone drug benefit under Medicare Part D administered by new Center for Medicare Choices in the Department of Health and Human Services (DHHS) and delivered through private risk-bearing entities. Government contracts with a private, non-risk-bearing plan that administers benefit (so-called "fallback") in regions with fewer than two private stand-alone drug plans. Drug benefits integrated with enhanced Part A and B benefits provided by private plans under new Medicare Advantage (Part C). All private plans share risk with government for drug benefit. Also provides subsidies for drug coverage to enrollees in qualified retiree plans and qualified state pharmaceutical assistance programs (SPAPs). Interim prescription drug discount card endorsement program (2004-2005) with government-subsidized card accounts for low-income.	Voluntary stand-alone drug benefit under Medicare Part D administered by new Medicare Benefits Administration in the Department of Health and Human Services (DHHS) and delivered through private risk-bearing entities. Drug benefits integrated with enhanced Part A and B benefits provided by private plans under Medicare Advantage (Part C) or new Enhanced Fee-for-Service (EFFS) plan options (Part E). Establishes competitive government contribution system (FEHBP-style reforms) in 2010 that includes traditional Medicare. Interim prescription drug discount card endorsement program (2004-2005) with government-subsidized card accounts for beneficiaries without other drug coverage.
Effective Date	1/1/2006 for new Part D benefit	1/1/2006 for new Part D benefit
Eligibility	Individuals entitled to Part A and enrolled in Part B may enroll in Part D, unless they receive full Medicaid benefits.	Individuals entitled to Part A or enrolled in Part B may enroll in Part D.
Benefit Package	All Part D Medicare Prescription Drug Plans (PDP) or Medicare Advantage plans must offer the standard benefit or its actuarial equivalent. Part D and Medicare Advantage plans (except Medical Savings Accounts plans) may also offer richer drug benefits in separate plan.	All Part D Medicare prescription drug plans (PDP), Medicare Advantage coordinated care plans, and EFFS plans must offer at least the standard drug benefit or its actuarial equivalent. Plans may offer richer coverage in lieu of standard coverage.
Monthly Premium	Part D standard coverage – about $35 on average in first year (2006) – based on enrollee's choice of plan. In Medicare Advantage, drug premium calculated in same way but may be offset by savings from other benefits. In general, Part D premiums are deducted from the beneficiary's monthly Social Security check.	Part D standard coverage – about $35 on average in first year (2006) – based on enrollee's choice of plan. In Medicare Advantage and EFFS, premium calculated in same way but may be offset by savings from other benefits. At enrollee option, Part D premiums may be deducted from beneficiary's Social Security check or paid through an electronic funds transfer.
Deductible	$275 (indexed to growth in per capita drug spending by Medicare beneficiaries).	$250 (indexed to growth in per capita drug spending by Medicare beneficiaries).

Cost-Sharing	50% up to initial coverage limit of $4,500; 100% between initial limit and stop-loss threshold; 10% above stop-loss threshold. (Thresholds are indexed.)	20% up to initial coverage limit of $2,000; 100% between initial limit and stop-loss; no coinsurance above stop-loss threshold. (Thresholds are indexed.)
Stop-Loss Threshold Applied to Out-of-Pocket Spending	$3,700 (indexed). After reaching threshold, 90% reimbursement. Excludes payments from other private insurance such as employer retiree health coverage.	$3,500 (indexed). After reaching threshold, 100% reimbursement. Excludes payments from other private insurance such as employer retiree health coverage. Special rules for qualified employer plans (see below).
Income-Related Stop-Loss Threshold	No provision.	Income-related stop-loss threshold for enrollees with incomes above $60,000/individuals and $120,000/couples. Treasury Secretary provides income information to HHS Secretary, who then discloses applicable out-of-pocket thresholds to drug plan sponsors.
Government Subsidies for General Medicare Population	About 70% of standard drug benefit costs provided through direct premium subsidies and reinsurance. Plans would receive reinsurance for 80% of actual net costs above stop-loss threshold for standard drug coverage (except qualified state pharmaceutical assistance plans would receive reinsurance of 65%).	Direct premium subsidies of 43% of national average premium for standard coverage; reinsurance of 30% of standard benefits in aggregate. Reinsurance payments of 20% for standard benefits $1,000-$2,000; 80% above stop-loss.
Government Subsidies for Low-Income Population—Premiums	Enrollees with incomes under 135% of poverty (including QMB, SLMB, QI,[i] as well as others who do not meet asset test) would receive a full premium subsidy for standard drug coverage up to the national weighted average premium (or lowest-cost plan if none was below the national average). Beneficiaries with incomes between 135% and 160% of poverty (no asset test) would receive additional premium subsidies determined on a linear sliding scale.	Enrollees with incomes up to 135% of poverty and who meet asset test would receive a full premium subsidy for standard drug coverage. Those with incomes between 135% and 150% of poverty and who meet the asset test would receive additional premium subsidies on a sliding scale. The asset test would be $6,000 single/$9,000 couple in 2006 and would be indexed to increase annually with inflation.
Government Subsidies for Low-Income Population—Cost-Sharing	QMBs would have no deductible; pay 2.5% coinsurance up to the initial limit, then 5% coinsurance to the stop-loss (i.e., the "donut hole") and 2.5% above the stop-loss. SLMBs and QIs would have no deductible, pay 5% coinsurance up to the initial limit, then 10% up to the stop-loss (i.e., the "donut hole") and 2.5% above the stop-loss. Beginning in 2009, the asset test for drug cost-sharing subsidies for individuals eligible for QMB, SLMB, and QI Part D benefits would be increased to $10,000 single/$20,000 couple and indexed in subsequent years. All other Part D enrollees with incomes below 160% of poverty would pay a $50 deductible (indexed); 10% coinsurance to the initial limit, then 20% to the stop-loss (i.e., "the donut	Enrollees with incomes up to 135% of poverty who meet an asset test (as above) would have no deductible and receive cost-sharing subsidies so that they pay no more than $2 for generics and $5 for brand drugs up to the initial coverage limit. Copayment amounts would be indexed to growth in per capita drug spending by Medicare beneficiaries. No low-income subsidies for costs of drugs between the initial limit and the stop-loss threshold (i.e., the "donut hole").

	hole") and 10% above the stop-loss.	
Treatment of Dual Eligibles	Medicare beneficiaries who receive full benefits, including prescription drugs, under Medicaid are not eligible for drug coverage under Medicare Part D. These beneficiaries would continue to receive drug coverage through Medicaid, according to each state's Medicaid plan.	All individuals entitled under Part A or enrolled in Part B, including those who are enrolled in Medicaid would be eligible to enroll in Medicare Part D (State government's obligation would be phased out). States would maintain Medicaid benefits as a wrap-around to Medicare benefits (at state option); states could require that these persons elect Part D drug coverage.
Administration of the Low-Income Subsidy	State Medicaid programs are required to evaluate eligibility for low-income subsidies using presumptive eligibility procedures, with states receiving enhanced matching rate for associated administrative costs. States must conduct eligibility determinations and enrollment at all Social Security field offices. Individuals determined to be eligible for Medicare cost-sharing assistance would be enrolled for such benefits under Medicaid. Administrator (Center for Medicare Choices) informs prescription drug plans of subsidy eligibility and level. Plans provide the subsidy and the Administrator reimburses the plans for their costs.	Eligibility for low-income subsidy program determined by state Medicaid program with states receiving enhanced matching rate for associated administrative costs, at an FMAP phasing up to 100% by 2019. Also, eligibility determinations by SSA, with additional funds to cover new administrative costs. Administrator (Medicare Benefits Administration) informs prescription drug plans of subsidy eligibility and level. Plans provide the subsidy, and the Administrator reimburses them for their costs.
Role of Private Plans/Traditional Medicare	Benefits provided through private, risk-bearing plans (shared risk with government through risk corridors in first years and reinsurance). Government contracts with private non-risk-bearing entity to provide coverage in areas with fewer than 2 private stand-alone PDPs.	Benefits provided through private, risk-bearing plans (shared risk with government through reinsurance). Administrator authorized to increase government risk as necessary (but not full risk) to guarantee 2 plan options (at least one stand-alone drug plan) in each area.
Payments to Drug Plan Sponsors	Part D - government pays plans an amount equal to the monthly approved premium, adjusted for risk and geographic price variations, from a combination of government contribution and enrollee premium. Government shares risk with drug plans through reinsurance (80% of allowable drug costs exceeding the catastrophic threshold) and risk corridors. Drug plans would be required to assume more but not total risk over time. Medicare Advantage plans are paid their premium amounts for drug coverage in a similar manner. The same reinsurance, risk corridor, stabilization fund, and administrative incentive provisions apply.	Part D - government pays plans an amount equal to the monthly approved premium, adjusted for risk. Payment is combination of government premium subsidy and enrollee share of premium. Government also provides reinsurance of 20% for costs $1,000-$2,000 and 80% above stop-loss. Medicare Advantage and EFFS plans receive payments for drug coverage in a similar manner and also receive reinsurance payments.
Covered Drugs	Drugs, biological products and insulin (including associated syringes and medical supplies as defined by the Administrator) that are covered under Medicaid and vaccines	Drugs, biological products and insulin (and medical supplies associated with the injection of insulin as defined by the Secretary) that are covered under Medicaid and vaccines licensed

	licensed under Section 351 of the Public Health Service Act. Includes coverage for any use of a covered outpatient drug for a medically accepted indication, as defined under Medicaid.	under Section 351 of the Public Health Service Act. Includes coverage for any use of a covered outpatient drug for a medically accepted indication, as defined under Medicaid.
Drugs Excluded from Coverage	Excluded would be drugs covered under Medicare Parts A or B (unless no benefits are payable), and those in categories that may be excluded under Medicaid (i.e., weight loss or gain, fertility, cosmetic or hair growth, cough or cold relief, vitamins and minerals, non-prescription drugs, barbituates, and benzodiazepines) except for smoking cessation agents. Drugs not covered because of a plan's formulary would be excluded if not successfully appealed. Drugs not meeting the Medicare definition of reasonable and necessary, or not prescribed according to requirements, could be excluded from coverage, but determinations would be subject to appeal.	Excluded would be drugs for which benefits are payable under Medicare Parts A or B, and those in categories that may be excluded under Medicaid (i.e., weight loss or gain, fertility, cosmetic or hair growth, cough or cold relief, vitamins and minerals, non-prescription drugs, barbituates, and benzodiazepines) except for smoking cessation agents. Drugs not covered because of a plan's formulary would be excluded if not successfully appealed. Drugs not meeting the Medicare definition of reasonable and necessary, or not prescribed according to requirements, could be excluded from coverage, but determinations would be subject to appeal.
Formularies	Plans may have a formulary so long as the formulary meets standards. Formularies must be developed by a pharmacy and therapeutic (P&T) committee that includes at least one academic expert, one practicing physician and one practicing pharmacist, all with expertise in the care of elderly or disabled; a majority of P&T committee must be practicing physicians or pharmacists; formulary must include drugs within each therapeutic category and class (as defined by the Administrator using certain compendia and other recognized sources); decisions must be based on the strength of scientific evidence and standards of practice; the committee must have procedures to educate providers concerning the formulary; and appropriate notice must be given to enrollees, pharmacists, and physicians before a drug is removed from the formulary.	Plans may have a formulary so long as the formulary meets standards. Formularies must be developed by a P&T committee that includes at least one practicing physician and one practicing pharmacist independent and free of conflict with respect to the committee, both with expertise in the care of elderly or disabled; the formulary must include drugs within each therapeutic category and class; decisions must be based on the strength of scientific evidence and standards of practice; the committee must have procedures to educate providers and enrollees concerning the formulary; and appropriate notice must be given to enrollees and physicians before a drug is removed from the formulary or the tier status of a drug is changed. In defining therapeutic classes, the committee would take into account standards published in the United States Pharmacopeia-Drug Information.
Access to Drugs Not on Formulary or Preferred Drug List	Beneficiaries could appeal for coverage of non-formulary drugs if the prescribing physician determines that the formulary drug is not effective for the patient or has significant adverse effects for the patient. In plans with tiered cost-sharing, enrollees may request that non-preferred drugs be covered as preferred drugs if the prescribing provider determines that the preferred drug is not effective or has adverse effects on the patient.	Beneficiaries could appeal for coverage of non-formulary drugs, or to have non-preferred formulary drugs be covered as preferred drugs, if the prescribing physician determines that the formulary drug either is not effective for the patient or has significant adverse effects for the patient, or both.
Drug Pricing	Plans would negotiate drug prices and must make the negotiated price available to	Plans would negotiate prices with manufacturers and suppliers of covered drugs.

	enrollees regardless of whether benefits are payable. Negotiated price is defined to include all discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations. Drug plan sponsors must provide that each pharmacy or dispenser of a covered drug inform the enrollee at the time of purchase of any differential between the price of the drug and the price of the lowest-cost generic equivalent. Drug prices negotiated for Part D (by a PDP, MA plan, or qualified retiree plan) would not be applicable to Medicaid "best price" provisions. If a Medicaid plan uses prices negotiated by a Medicare PDP to provide Medicaid assistance, Medicaid rebate provisions would not apply.	Enrollees must have access to their plan's negotiated prices even if no benefits are paid. Each plan must disclose to the Administrator the extent to which discounts or rebates or other remuneration or price concessions made available to the plan sponsor or organization by a manufacturer are passed through to enrollees through pharmacies and other dispensers or otherwise. The Administrator would have to keep this information confidential. PDP sponsors must provide that each pharmacy or dispenser of a covered drug inform the enrollee at the time of purchase of any differential between the price of the drug and the price of the lowest-cost generic equivalent. Drug prices negotiated for Part D (by a PDP, MA or EFFS plan, or qualified retiree plan) would not be applicable to Medicaid "best price" provisions. If states provide Medicaid assistance based on prices negotiated by a PDP, Medicaid rebate provisions would not apply.
Medicaid Financing	Medicaid continues to pay the full cost of providing drug coverage to duals (with usual FMAP) according to each state's Medicaid plan. States that provide a drug benefit under Medicaid that meets minimum standards would receive 100% federal funds for payment of the Part B premium for Medicaid and QMB eligibles with incomes between the SSI threshold and 100% of poverty. The minimum standards would be: meeting all current Medicaid standards for dual enrollees, including nominal cost-sharing; no limit on number of prescriptions; coverage of smoking cessation products; and meeting Part D standards for beneficiary protections.	All individuals eligible for Part A and enrolled in Part B are eligible for Part D drug benefits, including those who are also enrolled in Medicaid. Medicaid would continue (at state option) to provide wrap-around coverage for drug expenses in excess of Medicare benefits for dual enrollees, in accordance with each state's Medicaid plan. Federal Medicaid payments to states would be reduced by a declining percentage each year between 2006 - 2020 to offset the federal costs of providing Medicare drug benefits to individuals who would otherwise have received Medicaid drug benefits so that, by 2021, the Medicare program would assume full responsibility for Medicare drug benefits for these individuals.
▪ **Incentives to Maintain Coverage for Optional Medicaid Provisions**	In states with optional expansions of Medicaid to seniors and/or the disabled with income up to 100% of poverty, the federal government pays 100% (instead of usual FMAP) of Medicare Part A deductible and coinsurance costs for the expansion population. Applies only to states with optional expansions in place as of date of enactment.	No provision.

▪ **Medicaid Rebate** ▪ **Best Price Requirements**	If states elect to use prices negotiated by a PDP to provide Medicaid drug benefits, Medicaid rebate provisions would not apply. Prices negotiated for discount drug card endorsement program or Medicare Part D benefits by PDP, MA, and qualified employer plans would not apply to Medicaid "best price" requirements.	If states elect to use prices negotiated by a PDP to provide Medicaid drug benefits, Medicaid rebate provisions would not apply. Prices negotiated for Medicare Part D benefits by a PDP under Part D, by a MA-EFFS Rx plan under Parts C, or by a qualified employer plan would not apply to Medicaid "best price" requirements.
Treatment of Retiree Health Drug Coverage	Qualified retiree plans with drug coverage at least actuarially equivalent to Part D coverage would be eligible for same government subsidy per Medicare enrollee, based on national average premium (risk and geographically adjusted) for standard coverage. Also eligible for reinsurance of 80% of costs in excess of stop-loss threshold (but employer-covered costs do not count towards stop-loss).	Qualified retiree plans with drug coverage at least actuarially equivalent to standard Part D coverage receive subsidies of 28% of costs for coverage above deductible and up to $5,000 in 2006 in spending per Medicare enrollee (indexed thereafter).
Medicare Supplemental Insurance	No new Medigap policies providing drug coverage could be sold, issued, or renewed after January 1, 2006, to an individual enrolled in Part D. Medigap policies A through G must be guaranteed issued without preexisting condition exclusions to those terminating enrollment in Medigap plans with drug coverage (including nonstandard policies) and enrolling in Part D, if application is made during the Part D open-enrollment period. Medigap issuers must provide written notice during the 60 days before the initial Part D open-enrollment period to each policyholder with drug coverage of the ability to switch to a non-drug policy and that they are ineligible for Part D coverage as long as they retain a Medigap policy with drug coverage.	Beginning January 1, 2006, Medigap policies with drug coverage could no longer be sold except as replacements for policies with drug coverage. Beneficiaries with Medigap drug policies who enroll in Part D would be guaranteed issued a non-drug Medigap policy at the time of enrollment. NAIC would define 2 new Medigap packages that would cover some drug cost-sharing and partial coverage of beneficiary costs for other Medicare benefits. Medigap plans (other than the 2 new plans) would be prohibited from covering the deductible or more than 50% of the cost-sharing in an EFFS plan.
State Pharmacy Assistance Programs	Allows qualified state pharmaceutical assistance programs in operation as of the date of enactment to receive Medicare drug subsidies (in a manner similar to qualified retiree plans except that all plan payments apply towards stop-loss threshold and enrollees would qualify for subsidies for the low-income).	A State Pharmaceutical Assistance Transition Commission would be established as of the beginning of the third month after enactment to develop a proposal for addressing the unique transitional issues facing state pharmaceutical assistance programs and their participants due to the implementation of Medicare Part D.
Interim Drug Program	Establishes a Medicare Prescription Drug Discount Card Endorsement Program to operate in 2004-2005. Card programs would have to meet specific requirements and charge no more than $25 in annual enrollment fees. Low-income enrollees (QMB, SLMB, QI) would receive $600 per year, with balances carried forward on their cards from one year to the next. Government also pays enrollment	Establishes a Medicare Prescription Drug Discount Card Endorsement and Assistance Program to operate within 90 days of enactment through 2005. Card programs would have to meet specific requirements and charge $30 in annual enrollment fees ($20 for sponsor and $10 retained by government). For discount card program enrollees who do not have other prescription drug coverage (e.g., Medicaid,

	fee for low-income. Discount card sponsors must provide enrollees with access to negotiated prices, defined to include all discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations. Card sponsors with contracts to administer the low-income subsidies may not charge low-income enrollees more than average wholesale price (AWP) minus 20% for any covered drug.	group health plan, health insurance, etc.), the government would deposit to enrollee card accounts the following amounts: $800 for enrollees below 135% of poverty, $500 for enrollees with incomes between 135% and 150% of poverty, and $100 for enrollees with incomes above 150% of poverty. Balances in the accounts could be carried forward from one year to the next, and amounts could be contributed by employers and other individuals. Card sponsors would have to disclose to the Secretary the extent to which discounts or rebates or other remuneration or price concessions made available to it by manufacturers are passed through to enrollees through pharmacies and other dispensers or otherwise.
Financing of Drug Benefit	General federal revenues.	General federal revenues.
Medicare Private Plan Reforms Not Related to Drug Coverage	Renames Medicare+Choice as Medicare Advantage (MA) and reforms plan payment method. Increases payments to MA plans (see below). Adds new MA PPO option. All MA plans must offer coverage of Part A and Part B items and services, a unified deductible for those services, and an out-of-pocket limit. Plans must also offer standard Part D drug coverage.	Renames Part C, Medicare+Choice, as Medicare Advantage (MA) and reforms plan payment method. Increases payments to MA plans beginning in 2004, and moves to a FEHBP-style competitive approach beginning in 2010. Establishes Part E with new regional Enhanced Fee-for-Service (EFFS) plans. All MA and EFFS plans must offer coverage of Part A and Part B items and services, a unified deductible for those services, and an out-of-pocket limit. Plans must also offer standard Part D drug coverage. Establishes competitive government contribution system in 2010 that includes traditional Medicare.
Regional Plans	Establishes new regional PPO plans (and removes option for county-based PPO plans) offering enhanced benefits and covering large, defined regions, limited to 3 lowest-cost, credible PPO plans per region. PPO plans must serve an entire region or the entire U.S. At least 10 regions would be defined by the Administrator, each of which includes at least one state, and which cannot divide states. PPO plans paid in same manner as other MA plans, except have shared risk arrangements in first years. Generally, PPO plans must comply with standards applicable to MA coordinated care plans.	Establishes new regional Enhanced Fee-for-Service (EFFS) plans (but does not remove PPO or private fee-for-service options under Medicare Advantage) offering enhanced benefits and covering regions defined by the Administrator, with no more than 3 plans per region. Plans could be fee-for-service or PPOs. EFFS plans must serve an entire region (one of at least 10 defined by the Administrator after a survey of insurance markets). Generally, EFFS plans must comply with standards for MA private-fee-for-service plans.
Interim Plan Payments 2004-2005	Current law methodology except that the minimum increase would be 3% in 2005 instead of 2% (the amount of extra payment would not be carried forward for determining future rates).	In 2004, the capitation rate for each area would be the greater of current law rates or the adjusted average per capita cost (AAPCC) with direct medical education amounts removed. Budget neutrality would not apply to blend rates in 2004. Beginning in 2004, the minimum

		percentage increase would be equal to the national per capita growth rate (excluding any adjustments made before 2004 for projection errors).
VA/DOD Utilization by Medicare Beneficiaries	VA/DOD costs incorporated into calculation of capitation rates and local FFS rates for determination of the benchmarks, effective in 2006.	VA/DOD costs would be incorporated into the calculation of the capitation rates and the AAPCC in each area beginning in 2004.
Risk Adjustment	100% of payments to plans would be risk-adjusted beginning in 2006.	No change is made in implementation of risk adjustment (current law provides for a phase-in with 100% of rates to be subject to risk adjustment in 2007).
Plan Payments 2006 Forward	MA plans (including new regional PPOs) would submit bids for provision of Part A and Part B benefits (Part D drug benefits would be bid and paid separately). Plan bids would be compared to a benchmark calculated for the service area. Plans would be paid the benchmark amount by the government. Plans with bids above the benchmark would collect the difference directly from enrollees through premiums. Plans with bids below the benchmark must provide enrollees with 100% of the value of the difference between the bid and the benchmark through reduced Part B premium; lower cost-sharing; lower unified deductible and out-of-pocket limit; additional benefits and/or amounts placed in a stabilization fund to offset undue future fluctuations in extra benefits.	MA plans and EFFS plans would submit bids for provision of Part A and Part B benefits (Part D drug benefits would be bid and paid separately). Plan bids would be compared to a benchmark calculated for the service area. Plans with bids above the benchmark would be paid the benchmark and collect any additional amounts directly from enrollees through premiums. Plans with bids below the benchmark must provide enrollees with 75% of the value of the difference between the bid and the benchmark through reduction in premium for Part D or for extra benefits; cash; or other means approved by Administrator. The Administrator must provide a mechanism to consolidate enrollee premiums for Parts C and D. Plans must allow, at enrollee option, for premiums to be paid through deduction from Social Security checks, through an electronic funds transfer method, or otherwise.
Benchmark – MA Plans	The benchmark for each area or region would be the greater of the area capitation rate(s) or local fee-for-service costs. Area (i.e., county) capitation rates would continue to be calculated each year as the greater of the blend, the floor, or the 2% minimum increase. The local fee-for-service rate would equal benefit and claims processing costs for enrollees in original Medicare in the area minus graduate medical education amounts. Regional rates would be weighted averages of rates for areas within the region. Bids and benchmarks would be adjusted for number and health status mix of enrollees in each area.	The benchmarks for MA plans and EFFS plans would be the weighted average of the annual MA capitation rates for counties within each plan's service area (for EFFS plans, the service area is the region). Bids and benchmarks would be adjusted for demographics, risk, and geography.
"Premium Support" System	No provision.	Beginning in 2010, a new FEHBP-style competition program would be established in which traditional fee-for-service (FFS) Medicare would compete with MA and EFFS plans. Competitive areas would be those where there are at least two MA or EFFS plans with penetration of the lesser of 20% or the national

		MA+EFFS penetration rate. In competitive areas, a benchmark would be computed as the average of the adjusted average per capita cost (AAPCC) of FFS and the MA/EFFS plan bids, weighted by enrollment (the effects of the MA/EFFS plan bids would be phased-in over a 5-year period). Premiums for all beneficiaries in the area would be determined by comparing the plan bids (or, for FFS, the AAPCC without DME and with VA/DOD costs) to the benchmark. To the extent the AAPCC was more or less than the benchmark, beneficiaries in FFS Medicare would have an adjustment to their Part B premium (pay more equal to the difference if the AAPCC is higher than the benchmark; have the Part B premium reduced by 75% of the difference if the AAPCC is lower than the benchmark). The effect on Part B premiums would phase-in over 5 years to equal the full amount in 2015 and after. Enrollees in MA/FFS plans would realize the difference between their plan's bid and the benchmark through the premium (or rebate) associated with their plan.
Administration	Creates new agency within the Department of Health and Human Services called the Center for Medicare Choices.	Creates new agency within the Department of Health and Human Services called the Medicare Benefits Administration.
CBO 10-year Estimate	Not available.	Not available.

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

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

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

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

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