Medicare's New Directions

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ON DECEMBER 8, President George W. Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, implementing the most widespread and extensive changes to Medicare since its creation in 1965. The new prescription drug coverage has received the most publicity, but the Act contains many other changes. As the Act is nearly 700 pages long, this article presents only a brief overview.

Drug Benefit Program

The prescription drug benefit program is voluntary and contains a transitional Prescription Drug Discount Card program, and a permanent drug benefit program. In addition, Medicare Part B will continue to cover some medications as previously established.

Prescription Drug Discount Card Program. The Discount Card will give beneficiaries access to discount prices for prescription drugs until Medicare Part D goes into effect. All beneficiaries eligible for Medicare Part A, or who are enrolled in Medicare Part B and do not receive drug coverage under Medicaid, may receive a card. The maximum enrollment fee permitted is $30. The government will assist certain low-income individuals by paying the enrollment fee, and subsidizing medication costs up to $600 per year.

Medicare Part D. The permanent drug benefit program, Medicare Part D, takes effect on January 1, 2006. It will cover insulin, vaccines, certain biological products and other medically necessary prescription outpatient drugs currently covered by Medicaid. Medicare Part D will provide core drug benefits to beneficiaries through either an insurance-based Qualified Prescription Drug Plan (PDP) or an HMO-based Medicare Advantage Prescription Drug Plan (MA-PD). These drug plans must offer standard coverage or its actuarial equivalent. The standard plan requires that the beneficiary pay a $250 deductible, 25 percent of drug costs between $251 and $2,250, 100 percent of costs between $2,251 and $3,600, and a nominal copayment for costs exceeding $3,600. Again, the government will assist certain low-income individuals by paying their premiums and subsidizing medication costs.

Medicare Part B Drug Coverage. Medicare Part B will continue to cover (1) medications administered incident to a physician's services, (2) certain oral chemotherapeutic agents, (3) certain vaccines, (4) immunosuppressive medications after organ transplantation, and (5) drugs used with Durable Medical Equipment (DME). But the Act modifies reimbursement for these medications, generally increasing reimbursement for physician professional services and decreasing that for the drugs. Starting in 2005, physicians may elect to (a) purchase drugs and bill Medicare and the beneficiary directly, or (b) obtain drugs from a Competitive Acquisition Program contractor who will then bill Medicare and the beneficiary.

Medicare Advantage Program

The Act creates a Medicare Advantage (MA) program to replace Medicare + Choice. The Act creates regional and local MA plans starting January 1, 2006, and requires a competitive bidding process to establish a Medicare contract. Regional plans will be

preferred provider organizations (PPO) operating in large regions, some of which may cross state borders. Local plans will be similar to Medicare + Choice HMO plans, normally covering an area the size of a county.

To encourage the development and stability of regional plans, the Act places a moratorium on new local PPOs during 2006 and 2007. In addition, regional plans will receive a bonus for serving an area without a pre-existing regional plan. The Department of Health and Human Services (DHHS) will further encourage stability of the MA programs by sharing the financial risk, and by providing a bonus for continued service to discourage withdrawal from the program.

Other Modifications to Parts A and B

Durable Medical Equipment. Overall, the Act reduces reimbursement for durable medical equipment. It generally freezes DME payments from 2004 through 2008. Starting in 2007, the Act phases in a competitive bidding process for DME, enteral nutrients, and off-the-shelf orthotics. Contractors must meet certain quality and financial standards to be Medicare DME suppliers. DHHS will select a limited number of qualified suppliers, and only these suppliers may offer DME services to Medicare beneficiaries.

Hospitals. The Act generally improves hospital reimbursement, especially for rural hospitals. Inpatient Prospective Payment System (PPS) rates for hospitals will increase by the full market basket (a measure of hospital inflation) for 2004. From 2005 through 2007, hospitals can maintain this increase by participating in CMS's Hospital Quality Initiative. Nonparticipating hospitals will receive an update in reimbursement equal to the market basket rate less 0.4 percentage points per fiscal year. The Act also modifies the method of payments for new technology under the PPS, and provides wage index adjustments.

Specialty Hospitals. For 18 months after December 8, 2003, physicians may not own an interest in a specialty hospital, unless the hospital was in operation or under development as of November 18, 2003. During this moratorium, preexisting specialty hospitals cannot increase their hospital beds by more than 50 percent, cannot increase the number of physician investors, and cannot change their area of specialization.

Physician Services. The Act improves physician reimbursement by (a) increasing the conversion factor by at least 1.5 percent for 2004 and 2005, and (b) modifying the sustainable growth rate to prevent fluctuations in physician payments based on annual oscillations in economic performance.

Preventative Healthcare Services. Beginning January 1, 2005, Medicare will pay for the beneficiary's first screening physical exam if performed within 6 months of the start of Medicare coverage. The physical exam includes education, counseling, and referral for: (a) Pneumococcal, Influenza and Hepatitis B vaccines, (b) screening mammograms and pap smears, (c) screening tests for colorectal cancer, prostate cancer, glaucoma, diabetes, cholesterol and bone mass, (d) outpatient self management training programs for beneficiaries with diabetes, and (e) medical nutritional therapy. The physical examination generally does not include other clinical laboratory tests.

Additional Modifications. The Act also makes the following modifications to Medicare:

- reduces planned updates to the Ambulatory Surgery Center fee schedule;
- increases the renal dialysis composite rate by 1.6 percent for 2005;
- suspends the cap for physical, speech and occupational therapy services from December 8, 2003 to December 31, 2005;
- freezes reimbursement rates for clinical diagnostic laboratory tests from 2004 through 2008;
- requires DHHS to establish a chronic care improvement program by December 7, 2004;
- covers costs associated with Category A (experimental/investigational) devices if certain conditions are met;
- implements a sliding scale subsidy program for the Part B premium based on the

beneficiary's income; and
- permits importing prescription drugs from Canada if DHHS certifies they are safe.

The Act makes numerous changes to the existing Medicare program, some of them effective immediately and others not effective until the next decade. It also authorizes a large number of studies and demonstration projects. As a result, expect Congress and DHHS to continue to modify Medicare as additional information is gathered. Although many unknowns exist, this law insures that the Medicare program will remain in flux well into the next decade.

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