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**CONGRESS ENACTS BAUCUS MEDICARE BILL INTO LAW  
AS SENATE OVERRIDES PRESIDENTIAL VETO TONIGHT**

*Finance Chairman lead author of bill that put seniors first, won bipartisan support*

Washington, DC – Senate Finance Committee Chairman Max Baucus (D-Mont.) today won passage of the Medicare Improvements for Patients and Providers Act of 2008. The new law, based on a bill Baucus authored in the Senate, will make Medicare work better for the 44.1 million seniors enrolled, will reverse a 10.6 percent cut in the program’s payments to health providers for seniors and military families in the TRICARE program, and will save billions of dollars for taxpayers by reducing overpayments to some private Medicare plans.

The House and Senate passed the Medicare Improvements for Patients and Providers Act by overwhelming majorities. President Bush vetoed the bill today, requiring both chambers of Congress to vote on whether to override the veto and make the bill law.

**“Millions of Americans can go to sleep tonight knowing that they will be able to get the health care they need, because this Congress stood up, stood together, and stood by seniors and military families,”** said Baucus. **“From the doctor’s office to the drugstore, this new law will make Medicare work better for every beneficiary. I’m particularly proud that I was able to win \$4 billion in health care help for low-income seniors and for folks in rural states like Montana. The enactment of this new Medicare law shows that Congress can get good things done for the American people, when we’re willing to work together.”**

Information on key provisions of the bill can be found on the Finance Committee website at <http://finance.senate.gov/sitepages/medicare2008.htm>. An overview of provisions in brief follows here.

**A Better Program for Every Beneficiary**

- Authorizes coverage of new preventive services recommended by the U.S. Preventive Services Task force, and makes improvements to seniors’ “Welcome to Medicare” physical, including waiver of the deductible
- Cuts co-payments for mental health services to match other outpatient medical care
- Bans shady marketing practices by sellers of private Medicare plans, and limits other sales and marketing tactics that may be deceptive or confusing to seniors
- Ends the sale of Medigap plans that are redundant as a result of the drug benefit, and modernizes Medigap benefits to better meet seniors’ needs

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### **Help for Low-Income Seniors**

- Extends the Qualifying Individual (QI) program to pay outpatient coverage (Part B) premiums for seniors with incomes slightly above the poverty level
- Raises the asset limits for Medicare Savings Programs, increasing the amount of savings that low-income seniors can have and still qualify – from \$4,000 to \$7,790 for individuals, and from \$6,000 to \$12,440 for couples
- Enlists Social Security to help low-income seniors apply for the Medicare Savings Program, so more who qualify get assistance
- Eliminates penalties for late enrollment in the drug benefit by low-income seniors
- Ends a requirement that states collect back subsidies for Medicare cost sharing from the estates of deceased Medicaid beneficiaries
- Exempts the value of life insurance policies or assistance provided by churches and family members from the asset test for the low-income subsidy program in the Medicare drug benefit
- Ensures beneficiaries' right to a Federal court review if they are denied low-income subsidy
- Provides \$25 million to State Health Insurance Assistance Programs (SHIPs) and Area Agencies on Aging to help enroll low-income seniors in the Medicare Savings Program and the low-income subsidy for the Medicare drug benefit, and to help all seniors better navigate Medicare

### **Enhancements for Rural and Other Hospital Care**

- Extends the Medicare Rural Hospital Flexibility Program, which provides grants that rural health care providers can use to improve the quality of care facilities provide and to strengthen health care networks.
- Provides new authority for States to improve access to mental health care services for veterans in crisis and other residents of rural areas.
- Requires the use of more recent data to better reimburse sole community hospitals – the only hospital within 35 miles
- Establishes a demonstration project to allow states to test new ways to better coordinate hospital, nursing home, home health and other critical health care services in rural areas.
- Extends provisions providing certain hospitals additional payments to cover their labor costs under Medicare
- Revokes unique authority of the Joint Commission on the Accreditation of Healthcare Organizations to deem hospitals in compliance with Medicare Conditions of Participation

### **Proper Pay for Medicare Providers**

- Blocks a cut in physician payments for Medicare services, and increases payments by 1.1 percent in 2009.
- Extends and increases the Physicians' Quality Reporting Initiative (PQRI) bonus for providers who measure and report on quality of care
- Provides funding to a consensus entity to establish priorities for measuring health care quality
- Provides incentives to doctors who move to safer, more reliable electronic prescribing methods, decreasing payments to doctors who fail to do so by 2011

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- Expands access to primary by correcting a reduction applied to physician work and adding new funding and authority for the Medical Home Demonstration Project
- Extends an increase in the geographic adjustment to payment for physician work in rural areas
- Extends rules allowing independent laboratories to bill Medicare directly
- Helps physicians called to active military duty receive Medicare payments they're owed
- Implements an accreditation requirement for diagnostic imaging providers and tests the use of appropriateness criteria for such services
- Pays teaching anesthesiologists a full reimbursement for each patient under their care, and comparable treatment of nurse anesthetists as well

### **Payment and Coverage Improvements to Medicare Outpatient Services**

- Allows exceptions when seniors need additional medical therapy beyond current caps
- Extends current payment rules covering brachytherapy and radiopharmaceuticals
- Allows speech pathologists to bill Medicare directly for services
- Improves payments and coverage for patients with chronic obstructive pulmonary disease (COPD) and other conditions
- Delays and improves the competitive bidding program for durable medical equipment
- Repeals a competitive bidding demonstration for clinical laboratory tests and reduces scheduled increases in payments for these services
- Improves access to ambulance services, particularly in rural areas
- Ensures that critical access hospitals – small hospitals serving large rural areas – are properly paid for clinical lab services provided to Medicare beneficiaries
- Expands the sites at which beneficiaries are eligible to receive telehealth services in rural areas
- Requires MedPAC to study and report on improving chronic care programs
- Increases Medicare payments to community health centers
- Requires the establishment of programs to fight chronic kidney disease
- Increases payments for renal dialysis services, and bundles payments for dialysis drugs, testing supplies, and other elements into a single, more cost-effective payment for the treatment of End-Stage Renal Disease (ESRD)

### **Smart Reforms for Private Medicare Plans**

- Eliminates the “double payment” made to Medicare Advantage plans based on local costs for care at teaching hospitals – as teaching hospitals already receive extra payments directly for their sophisticated care
- Requires private fee-for-service plans in Medicare Advantage to develop networks of providers to ensure care for beneficiaries, and to measure and report on quality of care. Plans will no longer be allowed to “deem” a hospital or provider as part of the plan’s “network” without negotiating an actual contract for payment and care.
- Extends specialized Medicare Advantage plans’ authority to target enrollment of special needs individuals, and revises definitions, care management requirements, and quality reporting standards
- Limits co-payments for beneficiaries eligible for both Medicare and Medicaid when they are enrolled in specialized Medicare Advantage plans

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- Eliminates some funds from the Medicare Advantage Stabilization Fund for regional preferred provider organizations
- Extends authority to operate Section 1876 cost contracts
- Directs MedPAC to study ways to collect quality information and other comparison data for Medicare Advantage plans, and to study alternative payment formulas for MA

### **Improvements to the Drug Benefit**

- Requires prompt payment to pharmacies by prescription drug plans for medicines dispensed through the drug benefit
- Requires regular updates on pricing standards for drugs
- Reasonable requirements for submission of claims by long-term care pharmacies
- Includes barbiturates and benzodiazepines for drug benefit coverage
- Codifies current rules related to coverage of “protected classes” of drugs
- Revises definition of “medically accepted indication” for coverage of drug benefit medicines

Other provisions clarify the proper research uses of Medicare drug benefit data and address issues of quality reporting and health disparities. The bill also contains a number of improvements and extensions related to the Medicaid program, most notably a delay in the implementation of changes to “Average Manufacturer Price” calculations that would slash payments to pharmacies for dispensing generic drugs. Transitional Medical Assistance (TMA) and abstinence-only programs are extended through June 30, 2009. Other extensions include the Temporary Assistance for Needy Families supplemental grant program and Special Diabetes Grants.

In addition to the staff legislative summary, more detailed information on key aspects of the bill – help for rural seniors and all beneficiaries, physician provisions, bundling of dialysis payments for ESRD, Medicare Advantage reforms, and other measures – is on the Finance Committee website at <http://finance.senate.gov/sitepages/baucus.htm>.

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