Budget Reconciliation Package Contains Medicaid and Medicare Provisions Affecting Drug and Device Manufacturers

On December 21, 2005 the Senate passed a budget reconciliation bill by 51–50, with Vice President Cheney casting the tie-breaking vote. The Senate approved the bill after failing to waive the rules regarding extraneous matters in reconciliation bills (“Byrd Rule”). Sen. Conrad (D-ND) raised points of orders against three provisions in the House-passed conference report, effectively killing the conference report. (One provision limited providers’ liability if they denied non-emergency care to Medicaid beneficiaries who could not make copayments; the other two were described as technical provisions concerning Medicare-related reports.) The Senate then passed a substitute amendment that deleted the offending provisions and made at least one additional change, described below in this advisory. The House is expected to take up the measure shortly after returning from recess January 31st. Once enacted, the bill will be called the Deficit Reduction Act of 2005.

This client advisory briefly summarizes key Medicaid and Medicare provisions in the bill that will be of interest to pharmaceutical and device manufacturers.1 Specifically, the discussion below outlines the bill’s provisions on the following topics:

MEDICAID PROVISIONS

- Medicaid Drug Reimbursement
- Definition of AMP, Requirement for Regulations on AMP Calculations
- "Nominal" Prices and Best Price Calculations
- New Manufacturer Reporting Requirements
- Retail Survey Prices
- Collecting Medicaid Rebates on Physician-Administered Drugs

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1 We refer to “the bill” because any discrepancies between the budget reconciliation bills passed by the House and Senate that involve the provisions summarized here are specifically noted.
Authorized Generics and Medicaid Rebate Calculations
Extending Section 340B Prices to Certain Children’s Hospitals
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Implementation of Part B Premium Subsidy Reduction
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MEDICAID PROVISIONS

Medicaid Drug Reimbursement

Currently, multiple source drugs for which FDA has rated at least three products therapeutically and pharmaceutically equivalent are supposed to have a federal upper limit (FUL). As of January 1, 2007, section 6001 of the bill requires FULs when there are two therapeutically and pharmaceutically equivalent products, and reduces FULs to 250 percent of Average Manufacturer Price (AMP). The bill does not require FULs for single source drugs, or otherwise prescribe a reimbursement methodology for single source drugs. However, beginning July 1, 2006, the Centers for Medicare and Medicaid Services (CMS) must provide States with the most recent AMPS—as well as disclosing AMPS “through a website accessible to the public.” The bill also authorizes CMS to contract with a vendor that would calculate “retail survey prices” for drugs, which CMS would report to the States. Thus, over time State Medicaid programs will likely develop new reimbursement formulas for single source drugs based on AMP and/or retail survey prices.

Definition of AMP, Requirement for Regulations on AMP Calculations

Section 6001 of the bill amends the current definition of AMP so that it excludes customary prompt pay discounts to wholesalers. (Apparently this change occurs on January 1, 2007, as section 6001 provides that the amendments it makes take effect January 1, 2007 unless otherwise specified.) The change in the AMP definition will increase Medicaid rebates (both for innovator and non-innovator drugs), given the formulas for computing Medicaid rebates. The rebate formulas themselves have not been changed.

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) must recommend changes (by June 1, 2006) in the requirements for, and manner in which, AMPs are calculated. By July

2 This summary does not include summaries of the provisions relating to reduced payments to skilled nursing facilities for bad debt, updated payments for physician services, revised payments for therapy services, improvement in the delivery of services at federally-qualified health centers (FQHCs), waiver of Part B late enrollment penalty for certain international volunteers, revisions to home health payments, extension for paying claims that are not submitted electronically, phase-out of budget neutrality for risk adjustment for Medicare Advantage plans, or creation of a grant program for rural Programs for All-Inclusive Care for the Elderly sites.

3 Except for the cost-sharing provisions, the provisions discussed below all amend the Medicaid rebate statute (section 1927 of the Social Security Act (SSA), codified at 42 U.S.C. § 1396r-8).

4 More specifically, the bill substitutes 250 percent of AMP for “150 percent of the published price” (which usually is AWP) in the FUL regulation at 42 CFR § 447.32(b).

5 Retail survey prices are discussed further below.

6 As outlined below, AMP and Best Price calculations for brand name drugs with authorized generic versions would also be changed.
1, 2007, CMS must issue regulations clarifying AMP calculations, which must “take[e] into consideration” the OIG’s recommendations.

“Nominal” Prices and Best Price Calculations
Sales at a “nominal” price (prices below 10 percent of AMP) currently are excluded from manufacturers’ Best Price calculations. The bill limits this exclusion to nominally-priced sales to: (1) Section 340B covered entities; (2) intermediate care facilities for the mentally retarded; (3) State-owned or operated nursing facilities; and (4) other safety-net providers specified by CMS. This provision apparently takes effect January 1, 2007. By limiting the nominal prices that are excluded from Best Price calculations, it will likely increase Medicaid rebates on innovator drugs.

New Manufacturer Reporting Requirements
Section 6001 of the bill adds two new reporting requirements. Manufacturers will be required (apparently beginning January 1, 2007) to report to CMS customary prompt pay discounts to wholesalers. For calendar quarters beginning on or after January 1, 2007, manufacturers also will be required to report to CMS information on nominally-priced sales.

In addition, the bill may create confusion about the frequency of AMP and Best Price reporting. Section 6001 envisions manufacturers reporting AMP (and, apparently, Best Price) on a monthly basis instead of a quarterly basis; it amends SSA § 1927(b)(3)(A)(i) to provide: [Manufacturers with Medicaid rebate agreements shall report to the Secretary] not later than 30 days after the last day of each month of a rebate period under the agreement . . . on the average manufacturer price . . . and (for single source drugs and innovator multiple source drugs), the manufacturer’s best price . . . for covered outpatient drugs for the rebate period . . . .” (The underscored text is the amended language.) But section 6003 (concerning authorized generics) then strikes § 1927(b)(3)(A)(i) and replaces it with new language—which refers in part to AMP and Best Price being reported “not later than 30 days after the last day of each rebate period.”

Retail Survey Prices
Section 6001 of the bill provides that CMS may contract with a vendor for “the determination on a monthly basis of retail survey prices for covered outpatient drugs,” which prices shall represent “a nationwide average of consumer purchase prices for such drugs, net of all discounts and rebates (to the extent any information with respect to such discounts and rebates is available).” CMS must provide State Medicaid agencies with retail survey prices on at least a monthly basis.

States must annually report to CMS information on their Medicaid drug payment rates, dispensing fees, and generic utilization rates. For the 50 “most widely prescribed drugs” identified by CMS, CMS must annually compare the retail survey prices with Medicaid prices.

Collecting Medicaid Rebates on Physician-Administered Drugs
Currently, State Medicaid programs often do not collect Medicaid rebates on physician-administered drugs (because physicians bill for these drugs using HCPCS “J” codes, whereas National Drug Codes are needed in order to bill manufacturers for rebates). Section 6002 of the bill requires that State Medicaid programs begin obtaining NDC codes for certain physician-administered drugs reimbursed by Medicaid in order to obtain federal payments for those drugs.

Specifically, for a single source drug that is physician-administered (as determined by CMS) and that is administered on or after January 1, 2006, the State must collect “such

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7 The Joint Explanatory Statement of the Committee of Conference states that “[t]he conference agreement would increase the required reporting of AMP and best prices” and that “AMP would be reported and calculated on a monthly basis,” but does not explicitly state that Best Price would be reported on a monthly basis.

8 The vendor also will notify CMS when a drug product that is therapeutically and pharmaceutically equivalent and bioequivalent becomes generally available; within seven days after receiving such a notification, CMS must decide whether the product has become subject to FUL provisions.
utilization data and coding (such as J codes and National Drug Code numbers) as... [CMS] may specify as necessary to identify the manufacturer of the drug in order to secure [Medicaid] rebates.” Similar provisions apply to multiple source physician-administered drugs, except they are limited to multiple source drugs that: (1) are administered on or after January 1, 2008; and (2) are on a list that CMS must publish by January 1, 2007 of the 20 physician-administered multiple source drugs having the highest dollar volume under Medicaid. CMS may grant hardship waivers delaying these requirements (with respect to single source drugs, multiple source drugs, or both) if a particular State requires additional time to implement the new reporting system.

**Authorized Generics and Medicaid Rebate Calculations**

Authorized generics are addressed in section 6003 of the bill, “Improved Regulation of Drugs Sold Under a New Drug Application Approved Under Section 505(c) of the Federal Food, Drug and Cosmetic Act.” The provision consistently refers to drugs “sold under a new drug application approved under section 505(c) of the [FDCA],” and never uses the term “authorized generics.”

Section 6003 takes effect January 1, 2007. Manufacturers will need guidance from CMS in interpreting its provisions, which are confusing (and might extend beyond authorized generics, to drugs sold by repackagers under an NDA approved under FDCA § 505(c)).

**Best Price.** The definition of Best Price is amended by adding: “[I]n the case of a manufacturer that approves, allows, or otherwise permits any other drug of the manufacturer to be sold under a new drug application approved under section 505(c) of the [FDCA], [Best Price] shall be inclusive of the lowest price for such authorized drug available from the manufacturer during the rebate period to any manufacturer, wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States, excluding those prices described in [SSA § 1927(c)(1)(C)(i)(I)-(IV)].”

**AMP.** The definition of AMP is modified to provide that: “In the case of a manufacturer that approves, allows, or otherwise permits any drug of the manufacturer to be sold under a new drug application approved under section 505(c) of the [FDCA], such term [AMP] shall be inclusive of the average price paid for such drugs by wholesalers for drugs distributed to the retail pharmacy class of trade.”

**Reporting Provisions.** The provisions in the Medicaid rebate statute on reporting of AMP and Best Price also are amended and would now refer to drugs “sold under a new drug application approved under section 505(c) of the [FDCA].”

**Extending Section 340B Prices to Certain Children’s Hospitals**

Section 6004 of the bill amends the provisions in the Medicaid rebate statute concerning the Section 340B drug discount program, to require that manufacturers extend 340B prices to certain children’s hospitals.

SSA § 1927(a)(5) requires that (as a condition for a manufacturer’s drugs to be reimbursed by Medicaid and Medicare Part B) the manufacturer must have an agreement with HHS meeting the requirements of Section 340B with respect to drugs “purchased by a covered entity.”

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9 The 2008 date is confusing because elsewhere section 6002 requires that “[n]ot later than January 1, 2007, the information shall be submitted under subparagraphs (A) and (B)(iii) [concerning single source and multiple source drugs respectively] using National Drug Codes unless [CMS] specifies that an alternative coding system should be used.”

10 The Joint Explanatory Statement of the Committee of Conference states that section 6003 is similar to the Senate provision except that it “does not refer to the affected drugs as ‘authorized generics.’ Instead, the [conference] agreement uses the phrase ‘any drug of the manufacturer sold under a new drug application approved under section 505(c) of the Federal Food Drug and Cosmetic Act’ to include authorized generics . . . .”

11 SSA § 1927(c)(1)(C)(i)(I)-(VI) list the various prices that are excluded from Best Price calculations (except the nominal price exclusion, which appears at § 1927(c)(1)(C)(ii)(II)). It is not clear why the language quoted above does not refer to excluding nominal prices or those prices described in SSA § 1927(c)(1)(C)(i)(V) and (VI) (relating to certain prices negotiated with Medicare-approved discount card programs and with Medicare Part D plans or retiree plans that receive federal subsidies).

12 “Section 340B” refers to Section 340B of the Public Health Service Act (codified at 42 U.S.C. § 256b).
340B and (as amended by section 6004) “a children’s hospital [that meets specified criteria].” Because these children’s hospitals would not become covered entities under Section 340B itself, HHS should clarify that the double-discounting and diversion prohibitions in Section 340B apply to these hospitals.13

The children’s hospitals in question are those “described in [SSA] section 1886(d)(1)(B)(iii)14 which meet[] the requirements of clauses (i) and (iii) of section 340B(b)(4)(L) of the Public Health Service Act and which would meet the requirements of clause (ii) of such section if that clause were applied by taking into account the percentage of care provided by the hospital to patients eligible for [Medicaid].”15

Section 6004 applies to drugs “purchased on or after the date of the enactment of this Act.” Manufacturers will be unable to identify the children’s hospitals covered by this provision at the time of enactment—or at any time, for that matter—unless CMS or the Health Resources and Services Administration determines which hospitals meet the specified criteria and publish a list of those hospitals.

**Increases in Medicaid Cost-Sharing**

Currently, Medicaid beneficiaries’ cost-sharing obligations are limited to “nominal” amounts (and in certain cases any cost-sharing is prohibited). For non-institutional services, the maximum nominal coinsurance rate is 5 percent and the maximum nominal copayment is between $.50 and $3 (depending on the cost of the service).16 Sections 6041 and 6042 of the bill allow State Medicaid programs to establish alternative cost-sharing structures. Section 6041 addresses cost-sharing for services other than drugs (as well as addressing premiums), and section 6042 lays out special cost-sharing rules for prescription drugs.17

**General cost-sharing provisions (section 6041).** States may impose cost-sharing for non-drug services subject to specified limitations. For individuals with incomes between 100–150 percent of the federal poverty line (FPL), cost-sharing for a particular item or service may not exceed 10 percent of its cost, and aggregate cost-sharing (including drug cost-sharing) for all family members may not exceed 5 percent of family income. For individuals with incomes over 150 percent of FPL, cost-sharing for an item or service may not exceed 20 percent of its cost, and aggregate premiums and cost-sharing (including drug cost-sharing) for all family members may not exceed 5 percent of family income. Certain individuals and services are exempt from any cost-sharing.18

**Cost-sharing is also made “enforceable”; i.e., States may permit a provider, as a condition of providing care, to require that Medicaid beneficiaries pay authorized cost-sharing obligations.** (Currently,

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13 Prices to these hospitals clearly would be exempt from Best Price; the Best Price exemption for covered entities, SSA § 1927(c)(1)(C)(ii), refers to covered entities “described in subsection (a)(5)(B),” which is the specific provision amended by section 6004 of the bill.

14 SSA § 1886(d)(1)(B)(iii) refers to hospitals whose inpatients are predominately individuals under 18 years of age.

15 Section 340B(b)(4)(L) refers to a hospital described in SSA § 1886(d)(1)(B) that: (i) is owned or operated by a state or local government, is a public or private non-profit corporation formally granted governmental powers by a state or local government, or is a private non-profit hospital that has a contract with a state or local government to provide healthcare services to low-income individuals who are ineligible for Medicare and Medicaid; (ii) for the most recent cost reporting period ending before the calendar quarter involved, had a “disproportionate share adjustment percentage” (as calculated under SSA § 1886(d)(5)(F)) greater than 11.75 percent, or was described in SSA § 1886(d)(5)(F)(ii)(ii)(ll); and (iii) does not obtain covered outpatient drugs through a GPO or other group purchasing arrangement.

16 42 CFR § 447.54(a)(2),(3). The bill instructs CMS to index nominal cost-sharing amounts starting in 2006.

17 Section 6041 creates a new section 1916A of the Social Security Act, which is then amended by section 6042. Section 6043 also sets out special rules on emergency room copayments for non-emergency care.

18 Specifically, cost-sharing is not permitted for: (1) certain children under 18, and individuals receiving adoption or foster care assistance; (2) preventive services for children under 18; (3) pregnant women (for services relating to the pregnancy or a condition that may complicate the pregnancy); (4) terminally ill individuals receiving hospice care; (5) inpatients in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or other medical institutions (if they must spend all but a minimal amount of their income to receive services in the institution); (6) emergency services; (7) family planning services and supplies; and (8) women qualifying for Medicaid under the breast and cervical cancer group.
providers may not deny care to Medicaid beneficiaries due to their inability to pay cost-sharing charges.)

Special rules on drug cost-sharing (section 6042). To encourage use of “preferred drugs”—i.e., “drugs identified by the State as the least (or less) costly effective prescription drugs within a class of drugs (as identified by the State)”—States: (1) may set non-nominal cost-sharing amounts for nonpreferred drugs (subject to limitations outlined below); and (2) may waive or reduce cost-sharing for preferred drugs (and must not impose cost-sharing for preferred drugs on individuals exempt from cost-sharing under section 6041).19

There are several limitations on cost-sharing for nonpreferred drugs. First, cost-sharing must be nominal for individuals with incomes not exceeding 150 percent of FPL, and may not exceed 20 percent of the drug’s cost for individuals with higher incomes. Second, cost-sharing must be nominal for individuals exempt from cost-sharing under section 6041.20 Third, aggregate cost-sharing continues to be subject to the caps in section 6041. Finally, States shall limit cost-sharing for nonpreferred drugs to the amount for preferred drugs “if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both.”

MEDICARE PROVISIONS
Hospital Quality Reporting Requirements
The bill expands the requirements for the required submission of hospital data. CMS will expand the measures for the assessment of quality of care furnished by hospitals. Starting in fiscal year 2007, CMS will begin to adopt the performance measures described in the Institute of Medicine’s (IOM) November 2005 report; in fiscal year 2008, CMS will add other measures that reflect the consensus views of the affected parties and national consensus-building organizations. Hospitals that do not submit the required information to CMS will have their applicable market basket percentage increase reduced by 2 percent. CMS must make this data available to the public.

The bill further directs CMS to develop a plan to implement a value-based purchasing program for certain hospital payments beginning in fiscal year 2009. The plan must consider a number of issues, including the development of quality and efficiency measures, the reporting and collection of quality data, the structure of value-based payment adjustments, and the disclosure of hospital performance information.

The bill also changes the payment (as of October 2008) for discharges with certain secondary diagnoses that were not reported at the time of the patients’ admissions. The Secretary will select two diagnoses that result in higher payments to the hospital, but that represent conditions the hospitals could have reasonably prevented by following evidence-based guidelines (e.g., hospital-acquired infections). Beginning in October 2008, the hospital will not receive a higher payment based on the presence of these secondary diagnosis codes unless they were reported at the patient’s admission.

Determination of Medicaid Patient Days for Disproportionate Share Computation
The bill permits CMS to include patient days of patients who receive medical assistance under a § 1115 Medicaid demonstration project in the Medicare disproportionate share (DSH) computation. CMS may count these days as if they were provided to patients who were eligible for medical assistance under an approved Medicaid state plan. This provision does not apply to the reopening of any cost reports that have been closed at the date of enactment.

19 These are the eight exempt categories listed above in the summary of section 6041.

20 Again, these are the eight exempt categories listed earlier.
**Payments to Medicare-Dependent Hospitals**

The bill extends for five years, until October 2011, the special payment adjustment for hospitals categorized as Medicare dependent hospitals (MDHs). The bill also increases the MDH payment.

**Phase-In of Inpatient Rehabilitation Facility Classification Criteria**

To qualify as an Inpatient Rehabilitation Facility (IRF), facilities must meet certain criteria as determined by CMS. In May 2004, CMS issued a final rule revising the classification criteria, often referred to as the “75 percent rule” because it requires that starting in July 2007 at least 75 percent of patients treated by the facility must have specified medical conditions. The bill delays the 75 percent threshold until July 2008, and sets the threshold at 60 percent starting July 2006 and 65 percent starting July 2007.

**Physician Investment in Specialty Hospitals**

CMS must develop a plan to address issues regarding physician investment in specialty hospitals, focusing on the proportionality of investment return, bona fide investment, annual disclosure of investment information, provision of care to Medicaid patients and charity care, and appropriate enforcement. The suspension on enrollment under Medicare of new specialty hospitals will continue until CMS issues its final report to Congress or six months after enactment (whichever occurs first).

**Medicare Gainsharing Program Demonstration**

The bill creates a qualified gainsharing demonstration program “to test and evaluate methodologies and arrangements between hospitals and physicians designed to govern the utilization of inpatient hospital resources and physician work to improve the quality and efficiency of care” for Medicare beneficiaries and to “develop improved operational and financial hospital performance with sharing of remuneration.” The bill limits the number of demonstration projects to 6, and requires that 2 of these take place in rural areas. CMS will approve the demonstration projects by November 1, 2006 and the projects will be operational by January 1, 2007. The projects will conclude on December 31, 2009, with a final report from CMS to Congress due by May 1, 2010.

The demonstrations must have a written plan agreement, submitted to CMS prior to implementation, that outlines how they will achieve improvements in quality and efficiency. The plan must include certain patient protections, including the requirement that participating hospitals inform patients of the project and monitor patient care to ensure quality and efficiency is maintained or improved.

Demonstration projects shall involve arrangements in which the hospital provides remuneration to the physician that represents “solely a share of the savings incurred directly as a result of [their] collaborative efforts.” Furthermore, the demonstrations may not be structured in a way that rewards a physician on the basis of the volume or value of his or her referrals to the hospital.

**Post-Acute Care Demonstration**

By January 2008, CMS must establish a 3-year demonstration program for purposes of “understanding costs and outcomes across different post-acute care sites.” Under the new program, an individual who receives treatment from a provider for a diagnosis specified by CMS, will receive a comprehensive assessment of needs and clinical characteristics of the diagnosis to determine the appropriate placement of the patient in a post-acute care site. The assessment will be conducted using a standardized patient assessment instrument across all post-acute care sites. The demonstration program will take place at the number of sites necessary for statistically reliable results. Within 6 months of the program’s completion, CMS will submit a report to Congress describing the program’s results and CMS’s recommendations.
Beneficiary Ownership of Durable Medical Equipment
The bill changes the payments for certain types of durable medical equipment called “capped rental” items. Under the bill, Medicare generally will pay for the rental of these items for up to 36 consecutive months. After that period, however, the supplier of the equipment must transfer title to the beneficiary if the equipment was first rented beginning January 1, 2006. The bill also applies the 36-month rental period before ownership to oxygen equipment. In the case of power wheelchairs, the bill maintains the existing option for beneficiaries to purchase the item during the first month. After the transfer of title, payments for maintenance and service are provided (for parts and labor not covered by a warranty) if CMS determines them to be “reasonable and necessary.”

Payments for Imaging Services
In the final physician fee schedule rule for 2006, CMS reduced payments for certain multiple imaging services on a budget neutral basis; the bill provides that these payment reductions will not be taken into account for purposes of budget neutrality calculations. Thus the savings are returned to the government and not to physicians in the form of upward payment adjustments for other services. The bill also provides that the technical component for payment rates for certain imaging services cannot exceed the rate for the same services in hospital outpatient departments.

Payments to Ambulatory Surgical Centers
Currently, ambulatory surgical centers (ASCs) have a separate Medicare payment system. Beginning January 1, 2007, the bill would reduce ASC payments in cases where they otherwise would exceed the payment for the same service in hospital outpatient departments, to the hospital outpatient rate. This adjustment applies to ASC payments until CMS implements a revised ASC payment system (which, under the MMA, is supposed to occur by January 2008). These modifications are also carried over into budget neutrality provisions.

Transition of Hold Harmless Payments for Small Rural Hospitals
The prospective payment system for hospital outpatient department services (OPD) included a hold harmless provision designed to ensure that small rural hospitals are paid at least as much as they would have received under the previous cost-based methodology. For rural hospitals with no more than 100 beds that are not sole community hospitals, the bill essentially extends this hold harmless provision for an additional 3 years with relatively small reductions in the hold harmless payment (5 percent in 2006, 10 percent in 2007, and 15 percent in 2008).

Increase in Payments for Dialysis Services
The MMA changed how Medicare paid for dialysis treatments by requiring that CMS create a case mix-adjusted prospective payment system with two components: (1) the composite rate; and (2) a drug-related add-on adjustment. The bill updates the composite rate component of the dialysis payment system by 1.6 percent, for services supplied beginning January 1, 2006.

Implementation of Part B Premium Subsidy Reduction
The bill accelerates the reduction in Medicare Part B’s premium subsidy for higher-income beneficiaries (individuals with income over $80,000, couples with income over $160,000). Previously a 5-year phase-in from 2007 until 2011, the bill speeds up the reduction to 3 years. The subsidy reduction (i.e., the premium increase) will now be fully phased in in 2009, at which point higher-income beneficiaries will pay Part B premiums ranging from 35–80 percent of the value of Part B benefits.

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21 This is a change from the 13-month rental cap provision in the House-passed version of the bill (i.e., the conference agreement).
New Preventive Benefits
Beginning January 1, 2007, the bill provides for Medicare coverage of ultrasound screening for abnormal aortic aneurysms. The screenings will be available to beneficiaries who receive a referral and either have a family history of abdominal aortic aneurysm or are otherwise at risk. The bill also improves patient access to colorectal cancer screening by waiving the deductible for covered colorectal screening tests starting January 1, 2007.

We hope that you find this brief summary helpful. If you would like more information, please feel free to contact your Arnold & Porter attorney or:

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