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**MEDICARE PRESCRIPTION DRUG REFORM
PRELIMINARY SUMMARY OF CONFERENCE AGREEMENT
(Updated November 19, 2003)**

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**** All provisions are subject to change. The agreement has not been officially finalized.**

PROVISION	MEDICARE PRESCRIPTION DRUG CONFERENCE AGREEMENTS	NCSL POLICY
OVERVIEW		
General Approach	<ul style="list-style-type: none"> ▪ Effective January 1, 2006, a new “Voluntary Prescription Drug Benefit Program,” under a new Medicare Part D, would be established. ▪ The bill would rely on private plans to provide coverage and to bear a portion of the financial risk for drug costs. Federal subsidies would be provided to encourage participation. 	<ul style="list-style-type: none"> ▪ The prescription drug benefit should have no requirement relating to the use of state funds now used for existing state programs and should be: (1) Comprehensive; (2) Universal; (3) Affordable: The beneficiary share of the premiums should be set low enough so that individuals are not forced into the Medicaid program; and (4) Voluntary.
Fallback Plan	<ul style="list-style-type: none"> ▪ If no risk plans or fall back plans bid in a region, the fallback plan would provide coverage in that area. Fallback plans must offer the standard benefit, accept performance risk, and Medicare would set its premiums. 	<ul style="list-style-type: none"> ▪ No policy.
Cost Containment	<ul style="list-style-type: none"> ▪ Limits the portion of Medicare spending that comes from the federal Treasury to 45%. ▪ Beginning in 2005, each year the Medicare Trustees are directed to issue a report indicating whether projected excess general revenue funding¹ in the current year and the next 6 years is likely to exceed the 45% cap. If they report two years 	<ul style="list-style-type: none"> ▪ No policy.

¹ General revenue funding is total Medicare outlays minus “dedicated sources.” Dedicated sources is funding received outside the federal government and includes: (1) the Hospital Insurance (HI) payroll tax; (2) the income tax raised by the 1993 changes in taxation of OASDI benefits; (3) **amounts states pay the federal government through the “claw-back provisions” related to federal assumption of Medicare prescription drug coverage for Medicaid/Medicare dual-eligibles**; (4) premiums paid to Medicare; and (5) gifts to Medicare. Interest on trust fund assets is not considered a dedicated source.

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	consecutively that the program will exceed the cap, this would constitute a “Medicare funding warning,” and the agreement establishes a procedure for bringing the program into compliance. ²	
Competition	<ul style="list-style-type: none"> ▪ Comparative Cost Adjustment Program <ul style="list-style-type: none"> ▪ Establishes a demonstration program, beginning in 2010 in up to 6 Metropolitan Statistical Areas (MSAs) for 6 years. ▪ Demonstration sites chosen from MSAs with 2 local private plans with at least 25% total local private plan penetration. (Beneficiaries in counties within a triggered MSA that lack at least 2 private plans would not be affected). ▪ Part B premiums for beneficiaries remaining in traditional fee-for-service (FFS) program could not go up or down by more than 5% in any year as a result of the demonstration. ▪ Beneficiaries with incomes below 150% of poverty, who meet the asset requirements established for eligibility for low-income subsidies, would be protected from any Part B premium change as a result of the benchmark. ▪ Continued entitlement to defined benefits for all beneficiaries. 	<ul style="list-style-type: none"> ▪ No policy.
DRUG BENEFIT		
Overview	<ul style="list-style-type: none"> ▪ Beginning in 2004, Medicare beneficiaries may purchase prescription drug coverage from a private health plan that offers prescription drug coverage or from an insurance carrier offering a stand-alone prescription drug plan. ▪ Beneficiaries with incomes above 150% of the federal poverty level (FPL) will be responsible for: 	<ul style="list-style-type: none"> ▪ The prescription drug benefit should have no requirement relating to the use of state funds now used for existing state programs and should be: (1) Comprehensive; (2) Universal; (3) Affordable: The beneficiary share of the premiums should be set low enough so that individuals are not forced into the Medicaid program; and (4) Voluntary.

² After two consecutive reports that the program will exceed the 45% cap, the agreement calls for the President to submit legislation to Congress to reduce program expenditures to meet the cap. If the House fails to enact the proposed legislation by July 30th, the 88 members of the House may move to discharge a bill that addresses the problem. If the House votes to discharge the bill, which requires a majority, the bill moves to the House floor where it is subject to an “open rule” (up to 10 hours for amendments) that waives all points of order against germane amendments. The agreement calls for the House to consider the discharged bill within 3 legislative days after the discharge. In the Senate, the agreement provides that within three days upon receipt of the President’s legislative proposal, the Senate Majority Leader, Minority Leader or their designees will introduce the proposal and refer it to the Senate Finance Committee. If the Finance Committee failed to report the bill by June 30th, than a single motion to discharge would be in order. The motion to discharge would be subject to 2 hours of debate. If Congress enacted legislation that eliminated the excess general revenue (as certified by the Budget Committee chairman), the motion to discharge would not be available for the remainder of that session of Congress. Once legislation is placed on the Senate calendar, regular Senate rules apply, including the right to filibuster the motion to proceed or the bill.

³ Out-of-Pocket expenditures will be determined using the True Out-of-Pocket (TROOP) definition of stop/loss. Under this approach only contributions by the beneficiary, the beneficiary’s family, Medicaid, and state pharmacy assistance programs will count toward the stop/loss.

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	<ul style="list-style-type: none"> ▪ an average premium cost of \$35 per month (\$420 annual); ▪ a \$275 deductible; ▪ 25% coinsurance after the deductible is met, up to \$2,200 in expenditures. ▪ 100% coinsurance after they have spent \$2,200 on prescription drugs, up to the point when they have spent \$3,600 in out-of-pocket³ expenditures. ▪ 5% coinsurance after they have crossed the \$3,600 out-of-pocket threshold. ▪ \$2 copayment for generic drugs and \$5 copayment for brand name or non-preferred drugs. 	
<p>Low Income Subsidy – Beneficiaries with Incomes at or below 135% of the Federal Poverty Level (FPL)</p>	<ul style="list-style-type: none"> ▪ Low-income beneficiaries with incomes at or below 135% of FPL will be responsible for: <ul style="list-style-type: none"> ▪ \$0 premium costs ▪ \$0 deductible ▪ \$2 copayment for generic drugs and \$5 copayment for brand name or non-preferred drugs, through the “donut” and up to the stop-loss (\$3,600) ▪ No cost-sharing above the catastrophic level. ▪ An asset test will be applied (\$6,000 for singles/\$9,000 for couples). It will be indexed annually for inflation. 	
<p>Low Income Subsidy – Beneficiaries with Incomes between 135% - 150% of FPL</p>	<ul style="list-style-type: none"> ▪ Low-income beneficiaries with incomes between 135% - 150% of FPL will be responsible for: <ul style="list-style-type: none"> ▪ Premium subsidies on a sliding fee scale based on income; ▪ \$50 deductible ▪ 15% coinsurance up to the catastrophic limit ▪ \$2 copayment for generic drugs and \$5 copayment for brand name or non-preferred drugs, through the “donut” and up to the stop-loss (\$3,600). ▪ An asset test will apply (\$10,000 for singles/\$20,000 for couples). It will be indexed annually for inflation. 	

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TREATMENT OF MEDICARE PART B DEDUCTIBLES AND PREMIUMS		
Indexing Part B Deductible to Inflation	<ul style="list-style-type: none"> ▪ Increase the Part B deductible to \$110 in 2005, updated annually by the growth rate in the Medicare prescription drug program. 	<ul style="list-style-type: none"> ▪ No policy.
Income-Relate Part B Premium	<ul style="list-style-type: none"> ▪ Income thresholds: <ul style="list-style-type: none"> ▪ All beneficiaries under \$80,000 (single) \$160,000 couple continue to get 75% subsidy. ▪ 65% premium subsidy for beneficiaries between \$80,000 and \$100,000 ▪ 50% premium subsidy for beneficiaries between \$100,000 and \$150,000 ▪ 35% premium subsidy for beneficiaries between \$150,000 and \$200,000 ▪ 20% premium subsidy for beneficiaries over \$200,000 ▪ Five year phase-in of new premiums beginning in 2007. ▪ Income levels doubled for married couples. ▪ Permits beneficiaries to appeal if their family situation has changed (e.g., death of spouse, divorce). 	<ul style="list-style-type: none"> ▪ No policy.
MEDICAID – TREATMENT OF DUAL-ELIGIBLES		
Overview	<ul style="list-style-type: none"> ▪ Phases down state contribution to 75% over a 10-year period.⁴ ▪ Federal rules apply throughout the benefit. ▪ Imposes a copayment of \$1 for generics and \$3 for brand name drugs for dual-eligibles with incomes below 100% of FPL. ▪ Limits Medicaid wraparound to classes of drugs not covered by Medicare.⁵ 	<ul style="list-style-type: none"> ▪ NCSL call s for the federal government and Medicare beneficiaries to bear the cost of the Medicare program and provides that if additional low-income individuals are made eligible for the Medicare program through program reforms, including the establishment of a prescription drug benefit, the additional program costs should be 100 percent federally funded.
Program Administration	<ul style="list-style-type: none"> ▪ States will be responsible for determining for who qualifies for the: 	<ul style="list-style-type: none"> ▪ NCSL supported enhanced matching funds for state administration of eligibility determination for the low-income

⁴ The state contribution (MOE-maintenance of effort) would be based on FY 2002 or FY 2003 (to be determined) expenditures for prescription drug coverage for dual-eligibles. In the first four years, the MOE will be increased by the growth factor determined by the actuaries in the Centers for Medicare and Medicaid Services (CMS). The inflation factors they are currently working with are: 13.4% in FY 2003; 12.4% in FY 2004; 11.7% in FY 2005; and 11.1% in FY 2006. In FY 2007 and thereafter, when the Medicare Part D prescription drug program begins, the inflation factor will be based on the growth in Medicare prescription drug expenditures. After the inflation factor has been applied to the states base year, the phase-in percentage will be applied to the total. The phase-in will occur in 2.5% increments as follows: 97.5% in 2006; 95% in 2007; 92.55 in 2008; 90% in 2009; 87.5% in 2010; 85% in 2011; 82.5% in 2012; 80% in 2013; 77.5% in 2014 and 75% in 2015 and thereafter. This provision is referred to as the “claw back” provision. **The state MOE for dual-eligible will be officially counted as part of Medicare revenue in the federal budget.**

⁵ States may wrap-around the Medicare drug benefit provided they use only state funds.

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	<ul style="list-style-type: none"> ▪ voluntary prescription drug benefit (Medicare Part D); ▪ low-income subsidies for Part D premiums and cost-sharing; and ▪ transitional prescription drug discount card program. ▪ No enhanced matching for administrative costs associated with making eligibility determinations for the low-income subsidy programs. 	subsidy programs.
MEDICAID		
Increase In Medicaid DSH Allotments For Fiscal Years 2004 And 2005	<ul style="list-style-type: none"> ▪ Increases state DSH allotments in FY 2004 by 16 percent. Thereafter, allotments remain at the FY 2004 allotment level subject to the 12 percent limit established in BBA 1997 until the year in which current law “catches up” with the new proposal’s allotments. When that occurs, allotment levels will be the previous year’s allotment increased by the CPI-U, subject to the 12 percent limit. 	<ul style="list-style-type: none"> ▪ NCSL supports an increase in state DSH payments.
Increase in floor for treatment as an extremely low DSH State under the Medicaid program for fiscal years 2004 and 2005	<ul style="list-style-type: none"> ▪ Low DSH states will receive a 16% increase annually for five years. [Translates to a 1.5% rate in five years] 	<ul style="list-style-type: none"> ▪ NCSL supports.
Clarification Of Inclusion Of Inpatient Drug Prices Charged To Certain Public Hospitals In The Best Price Exemptions For The Medicaid Drug Rebate Program.	<ul style="list-style-type: none"> ▪ Exempts 340B public hospital purchases of inpatient drugs from the Medicaid “best price” calculations. ▪ Establishes an anti-diversion provision that subjects any drug for inpatient use covered under the 340B program to the auditing and record keeping requirements of the 340B program. 	<ul style="list-style-type: none"> ▪ No policy.
Background Checks for Employees of Long Term Care Facilities	<ul style="list-style-type: none"> ▪ Establishes a two-year demonstration with \$25 million in mandatory funding for background checks. ▪ Provides that up to 10 states may participate in the demonstration project. 	<ul style="list-style-type: none"> ▪ NCSL policy addresses the original provision in the Senate bill that would have required states to conduct background checks for all long term care services workers in nursing facilities, home health agencies, hospices and similar settings ▪ NCSL supports continued vigilance in the protection of people receiving long term care services in all venues, but urged Congress to explore options that may be less costly, less administratively burdensome and that would include funding for the administrative costs incurred by the facilities for implementing the background checks.
Assistance With Coverage Of Legal Immigrants Under The		<ul style="list-style-type: none"> ▪ NCSL supports a state option to provide Medicaid and/or

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Medicaid Program And SCHIP.	<ul style="list-style-type: none"> ▪ No provision at press time. (See note) 	SCHIP coverage to legal immigrants.
FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES PROVIDED TO UNDOCUMENTED IMMIGRANTS		
Federal Reimbursement Of Emergency Health Services Furnished To Undocumented Immigrants	<ul style="list-style-type: none"> ▪ Permits reimbursement to providers for the uncompensated provision of emergency health services to immigrants who have been allowed to enter the United States for the sole purpose of receiving such services. ▪ Appropriates \$250 million annually for fiscal years 2005-2008, \$167 million of which would be allotted to the 50 states in proportion to each state’s proportionate share of undocumented immigrants residing in the United States. The remaining funds would be allotted to the 6 states with the highest number of apprehensions of undocumented immigrants. 	<ul style="list-style-type: none"> ▪ NCSL supports.
DIRECT SUBSIDY PAYMENTS FOR SPONSORS OF QUALIFIED RETIREE PRESCRIPTION DRUG PLANS		
Direct Subsidy for Sponsors of Qualified Retiree Prescription Drug Plans for Plan Enrollees Eligible for, but Not Enrolled in a Medicare Prescription Drug Plan	<ul style="list-style-type: none"> ▪ Clarifies that state and local governments are eligible for the subsidy. ▪ Subsidy payments would equal 28% of allowable costs over the \$250 deductible and up to \$5,000. (The dollar amounts would be adjusted annually by the percentage increase in Medicare per capita prescription drug costs.) ▪ The employer subsidy for retiree prescription drug coverage is excludable from taxation.⁶ ▪ Qualified retiree health plans have maximum flexibility on plan design, formularies and networks. ▪ Employers may also provide premium subsidies and cost-sharing assistance for retirees that enroll in a Medicare prescription drug plan or an integrated plan. ▪ Employers may negotiate preferential treatment from integrated plans. 	<ul style="list-style-type: none"> ▪ NCSL supports.
DIRECT SUBSIDY PAYMENTS FOR QUALIFIED STATES OFFERING A STATE PHARMACEUTICAL ASSISTANCE PROGRAM		
Direct Subsidy for Qualified States Offering a State Pharmaceutical Assistance Program for Program	<ul style="list-style-type: none"> ▪ Requires coordination of benefits with “qualified” state pharmacy assistance programs. 	<ul style="list-style-type: none"> ▪ NCSL supports.

⁶ State and local governments cannot take advantage of the tax exclusion. For this reason, the benefit to for-profit entities is greater than the 28% subsidy available to state and local governments and non-profit entities.

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Enrollees Eligible for, but not Enrolled in a Medicare Prescription Drug Plan		
DISCOUNT DRUG CARD		
Card Availability	<ul style="list-style-type: none"> ▪ The Medicare-endorsed drug discount cards will be available no later than 6 months after enactment, and would end when the prescription drug benefit becomes available to the beneficiary in 2006. A transition provision would ensure an appropriate transition for ending the discount card and beginning the drug benefit. ▪ Beneficiaries would have a choice of at least two Medicare endorsed cards. ▪ Cards would be available on at least a statewide basis, except for Medicare+Choice sponsors who could offer cards in their service area. 	<ul style="list-style-type: none"> ▪ No policy.
Eligibility	<ul style="list-style-type: none"> ▪ All Medicare beneficiaries would be eligible for the card, except those enrolled in Medicaid and entitled to Medicaid drug coverage. Individuals could only enroll in one Medicare-endorsed card at a time. ▪ In 2004, individuals may change their designated drug card for 2005. 	<ul style="list-style-type: none"> ▪ No policy.
Program Design	<ul style="list-style-type: none"> ▪ There would be a continuous open enrollment for beneficiaries, and a standard enrollment form. ▪ The Secretary would disseminate card information, enrollment information and availability of transitional assistance to beneficiaries. ▪ Card sponsors could charge an annual enrollment fee of up to \$30, which may be paid by a State. ▪ Card sponsors would offer beneficiaries access to negotiated prices. 	<ul style="list-style-type: none"> ▪ No policy.
Drug Card Sponsors	<ul style="list-style-type: none"> ▪ Pharmacy Benefit Managers (PBMs), wholesalers, retail pharmacies, insurers, or Medicare+Choice plans could be sponsors of a Medicare-endorsed drug card. Sponsors must: <ul style="list-style-type: none"> ▪ obtain approval from the Secretary in order to offer the Medicare endorsed card. ▪ provide information on enrollment fees and negotiated 	<ul style="list-style-type: none"> ▪ No policy.

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	<p>prices for drugs.</p> <ul style="list-style-type: none"> ▪ provide convenient access to pharmacies (using the TRICARE access standard). ▪ administer a system to reduce medication errors and prevent adverse drug interactions. ▪ maintain a grievance process to resolve disputes. ▪ Sponsors are precluded from marketing non-drug products to Medicare beneficiaries. 	
Transitional Low-Income Assistance	<ul style="list-style-type: none"> ▪ All individuals with income under 135 percent of the federal poverty level would be eligible for transitional assistance unless they have third party coverage from an employer, the Department of Defense, Medicaid or the Federal Employees' Health Benefit Program (FEHBP). ▪ Individuals would self-certify income, but HHS through Medicaid, the Social Security Administration, or tax information, subject to strict confidentiality constraints would verify eligibility. There would be no asset test. ▪ Up to \$600 per year would be provided in conjunction with the discount card to purchase prescription drugs, but the amount may be prorated for beneficiaries who enroll for part of a year. The Secretary would pay the annual enrollment fee. ▪ Eligible beneficiaries below 100% of FPL would pay a 5% coinsurance on each discounted drug. ▪ Eligible beneficiaries between 101%- 135% of FPL would pay a 10% coinsurance on each discounted drug. 	<ul style="list-style-type: none"> ▪ No policy.
MISCELLANEOUS PROVISIONS		
Beneficiary Protections	<p>Previous Tentative Conference Agreement</p> <ul style="list-style-type: none"> ▪ Requires plans to provide medication therapy management by pharmacy providers targeted to beneficiaries who: (1) have multiple chronic conditions; (2) use multiple prescriptions; and (3) are likely to incur high drug expenses. ▪ These programs would ensure appropriate use of prescription drugs to improve therapeutic outcomes and reduce adverse drug interactions. ▪ Requires plans to take into account medication therapy 	<ul style="list-style-type: none"> ▪ No policy.

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	management services when determining reimbursement for pharmacists.	
Standards for Electronic Prescribing	<ul style="list-style-type: none"> ▪ Plans [must/may] require prescriptions to be written and transmitted electronically. ▪ Prescribing health providers would receive relevant information from plans on medical history, lower cost drugs, eligibility and benefits, drugs included on the formulary, and information on potential adverse drug interactions. ▪ Discretionary grants would be available to assist providers in implementing electronic prescription programs. 	<ul style="list-style-type: none"> ▪ No policy.
RURAL EQUITY		
Overview	<ul style="list-style-type: none"> ▪ The Conference agreement includes a wide variety of provisions to improve access to health services in rural areas. 	<ul style="list-style-type: none"> ▪ NCSL supports efforts to provide equity in payments to rural and urban providers. While we support rural equity, we believe it must be achieved in a way that does not take needed funds away from more urban areas. NCSL urges the Congress to include provisions that would equalize payments to hospitals and that would adjust the formula for determining payments in a way that better reflects costs.
Equalizing Urban And Rural Standardized Payment Amounts Under The Medicare Inpatient Hospital Prospective Payment System.	<ul style="list-style-type: none"> ▪ Standardized amount continued without pause. Effective April 2004. 	
Fairness In The Medicare Disproportionate Share Hospital (DSH) Adjustment For Rural Hospitals.	<ul style="list-style-type: none"> ▪ Increases cap on payments for small rural and urban hospitals from 5.25% to 12%, starting in FY 2004. 	
Revision Of Acute Care Hospital Payment Updates (Preliminary Conference Agreement)	<ul style="list-style-type: none"> ▪ The hospital update would be set at market basket (current law) for FY 2004. ▪ Payments would be reduced by .4% in FY 2005, FY 2006, or FY 2007 if the hospital did not furnish quality data to CMS.⁷ 	
Adjustment To The Medicare Inpatient Hospital PPS Wage Index To Revise The Labor-	<ul style="list-style-type: none"> ▪ Beginning in FY 2005 decreases the labor-related share from 71% to 62% in low wage areas, unless the change would result in lower payments to a hospital. 	

⁷ Hospitals would submit data to CMS for a specified set of indicators related to the quality of care provided to Medicare patients. Indicators would build on CMS' experience with the ongoing Hospital Quality Incentive Data initiative being conducted with the major hospital trade groups.

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Related Share Of Such Index.		
Wage Index Adjustment Reclassification Reform	<ul style="list-style-type: none"> ▪ Establishes a new process, similar to the current wage index reclassification process, based on commuting data, which would enable hospitals to receive a blended wage index amount based on the percent of employees, which commute from adjacent MSAs. 	
More Frequent Update In Weights Used In Hospital Market Basket	<ul style="list-style-type: none"> ▪ Directs the Secretary to update the weights for the hospital market basket more frequently than once every 5 years. 	
Medicare Inpatient Hospital Payment Adjustment For Low-Volume Hospitals.	<ul style="list-style-type: none"> ▪ Effective FY 2005, establishes a graduated adjustment/add-on payment to inpatient hospital PPS rates for low-volume hospitals. ▪ Eligible hospitals that have fewer than 800 total discharges annually and are 25 miles away from a similar hospital. The maximum total adjustment is 25% of the otherwise applicable PPS rate. ▪ Payment adjustment will be based on empirical relationship between discharges and costs. 	
Critical Access Hospital (CAH) Improvements.	<p>Previous Tentative Conference Agreement</p> <ul style="list-style-type: none"> ▪ <u>Payment Increase</u> – Increases CAH reimbursement to 101% of reasonable costs. Effective date not specified. ▪ <u>Emergency Services</u> – Authorizes payment of physician assistants, nurse practitioners, and clinical nurse specialists as emergency room on-call providers (in addition to physicians). Effective date not specified. ▪ <u>Flexibility in Bed Limit</u> – Allows CAHs experiencing seasonal fluctuations in patient admissions an additional 5 beds. Allows up to 25 beds to be used for acute care (under the new limit), provided that no more than 10 beds are swing beds. Effective date not specified. ▪ <u>CAH Eligibility</u> – Allows hospitals with no more than 10 psychiatric or rehabilitation beds to become CAHs. ▪ <u>Periodic Interim Payments</u> – Authorizes periodic interim payments (PIPS), effective 1/1/04. Requires the Secretary to develop alternative methods for PIIPs based on expenditures by CAHs. ▪ <u>Rural Flexibility Grants</u> – Authorizes \$35 million annually 	

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	<p>with 95% of the funds set aside for hospitals.</p> <ul style="list-style-type: none"> ▪ <u>Physician Bonuses</u> – Eliminates the barrier for receiving a physician bonus. 	
Revision of Federal Rate For Hospitals In Puerto Rico.	<ul style="list-style-type: none"> ▪ Permanently increases the PPS rate for hospitals in Puerto Rico to 75% of the national rate over a 2-year transition period. 	
Recognition of Attending Nurse Practitioners As Attending Physicians To Serve Hospice Patients	<ul style="list-style-type: none"> ▪ Nurse practitioners would be able to continue to treat their patients who enroll in hospice programs. 	
Providing Safe Harbor For Certain Collaborative Efforts That Benefit Medically Underserved Populations	<ul style="list-style-type: none"> ▪ Creates a safe harbor for donations and other remuneration used to improve services at FQHCs. 	
Treatment of Missing Cost Reporting Periods For Sole Community Hospitals	<ul style="list-style-type: none"> ▪ Hospitals that are missing cost reports will be eligible for sole community status if one base year cost report is available. 	
Revision of The Indirect Medical Education (IME) Adjustment Percentage.	<ul style="list-style-type: none"> ▪ Increases IME from 5.5% to 6.0% for the last half of FY 2004; 5.8% in 2005; 5.55% in FY 2006; and 5.35% in FY 2007. 	
Establishment Of Floor On Geographic Adjustments of Payments For Physicians' Services.	<ul style="list-style-type: none"> ▪ Sets floor on work geographic adjuster at one for 2004 through 2006. 	
Medicare Incentive Payment Program Improvements.	<ul style="list-style-type: none"> ▪ Establishes a new 5% bonus payment for physicians in physician scarcity areas for 2005-2007. 	
Extension of Hold Harmless Provisions For Small Rural Hospitals And Treatment of Certain Sole Community Hospitals To Limit Decline In Payment Under The OPD PPS.	<ul style="list-style-type: none"> ▪ Extends the hold harmless for hospital outpatient services performed in small rural hospitals for two years. ▪ Directs the HHS Secretary to review the prospective payment rates during the two-year period. 	
Temporary Increase For Ground Ambulance Services.	<ul style="list-style-type: none"> ▪ Ambulance payments based on the regional floor and the adjustment for low population rural areas plus a 1% across the board increase for urban areas and a 2% across the board 	

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	increase for rural areas for two and a half years.	
Elimination of consolidated billing for certain services under the Medicare PPS for skilled nursing facility services.	<ul style="list-style-type: none"> ▪ Eliminates consolidated billing for professional services provided by rural health clinics and FQHSs. 	
Freeze In Payments For Certain Items of Durable Medical Equipment And Certain Orthotics; Establishment of Quality Standards And Accreditation Requirements For DME Providers.	<ul style="list-style-type: none"> ▪ Freezes reimbursement for durable medical equipment or orthotics (excluding custom-fabricated) from 2004 – 2006. The rates for the top five services will be adjusted to reflect prices paid under the Federal Employees Health Benefit Program (FEHBP) plans. ▪ Competitive bidding for the largest MSAs begins in 2007, phasing up to 80 MSAs in 2009. Competitive bidding prices will be applied nationwide for those selected services 	
Application of Coinsurance And Deductible For Clinical Diagnostic Laboratory Tests.	<ul style="list-style-type: none"> ▪ Imposes a 7-year freeze on laboratory payment rates. 	
Payments to Oncologists for In-Office Cancer Drug Administration.	<p>Payments to Oncologists for In-Office Cancer Drug Administration</p> <ul style="list-style-type: none"> ▪ Increase practice expense reimbursements for drug administration. <ul style="list-style-type: none"> ▪ Examine existing codes for drug administration and exempt any revisions from budget neutrality requirement. ▪ Allow for supplemental surveys on practice expenses for drug administration, and exempt any resulting changes from budget neutrality. ▪ Require MedPAC review of payment changes as they affect payment and access to care by January 2005 for oncologists, and by January 2006 for other affected specialties. 	<ul style="list-style-type: none"> ▪ NCSL supports continued Medicare coverage of intravenous therapy for cancer patients in their oncologists' offices.
Basing Medicare Payments For Covered Outpatient Drugs on Market Prices.	<ul style="list-style-type: none"> ▪ AWP minus 15% in 2004. <ul style="list-style-type: none"> ▪ The Secretary would have authority to increase or decrease reimbursement based on market surveys. ▪ Average sales price (ASP) plus an additional percentage beginning in 2005. 	<ul style="list-style-type: none"> ▪ No policy.

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	<ul style="list-style-type: none"> ▪ Competitive bidding as a physician choice beginning in 2006. ▪ Secretary has the authority to adjust reimbursement for a drug, where the ASP is found to not reflect widely available market prices. ▪ Manufacturers would be required to report ASP data. Manufacturer reporting of false ASP information would be a violation of the False Claims Act. ▪ The HHS Inspector General would be required to regularly audit manufacturers submitted ASPs and compare them with widely available market prices and Medicaid Average Manufacturer Prices (AMP). 	
Treatment of Specialty Hospitals - Clarifications to certain exceptions to Medicare limits on physician referrals	<ul style="list-style-type: none"> ▪ Imposes an 18-month moratorium of the self-referral whole hospital exemption for new specialty hospitals.⁸ ▪ Existing hospitals may add up the greater of 5 beds or 50% of the beds on their current campus. ▪ During the moratorium period, MedPAC is to conduct an analysis of the costs of the specialty hospitals and whether the payment system should be refined. ▪ Directs the HHS Secretary to examine referral patterns and quality of care issues. 	
Payment for Covered Skilled Nursing Facility Services	<ul style="list-style-type: none"> ▪ Medicare payments to skilled nursing facilities will be refined to reflect the high cost of treating patients with AIDS. 	
HOME HEALTH		
Update In Home Health Services	<ul style="list-style-type: none"> ▪ Provides for market basket minus .8% for 2004-2006. ▪ Continues current outlier policy of allocating no more than 3% for outliers. 	
COVERAGE IMPROVEMENTS		
Coverage of Hospice Consultation Services	<ul style="list-style-type: none"> ▪ Provides reimbursement for hospice physicians for educating patients about the program. 	<ul style="list-style-type: none"> ▪ No policy.
Inclusion of Podiatrists and Dentists Under Private Contracting Authority	<ul style="list-style-type: none"> ▪ Extends to podiatrists and dentists the current law authority to utilize private contracts. 	<ul style="list-style-type: none"> ▪ No policy.

⁸ New specialty hospitals would not include existing hospitals or those under construction as specified in the Senate bill, effective the day the House files the bill.

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One-year Moratorium on Therapy Caps	<ul style="list-style-type: none"> Imposes a one-year moratorium on therapy caps. 	<ul style="list-style-type: none"> No policy.
Payment for Certain Shoes and Inserts Under the Fee Schedule for Orthotics and Prosthetics	<ul style="list-style-type: none"> Establishes a fee schedule amount for custom shoes for diabetic patients. 	<ul style="list-style-type: none"> No policy.
Medicare Coverage of Diabetes Laboratory Diagnostic Tests	<ul style="list-style-type: none"> Establishes coverage of diabetes screening lab tests for persons at risk for diabetes 	<ul style="list-style-type: none"> No policy.
Coverage of Routine Costs Associated with Certain Clinical Trials	<ul style="list-style-type: none"> Establishes improvements on national and local coverage policy and expansion of clinical trials. 	<ul style="list-style-type: none"> No policy.
COVERAGE FOR PREVENTIVE SERVICES		
Improved payment for certain mammography services.	<ul style="list-style-type: none"> Moves screening and diagnostic mammography from OPPS to the physician fee schedule. (Effective date not specified). 	<ul style="list-style-type: none"> NCSL urges Congress to increase support for initiatives that promote regularized preventive health screenings and check-ups. NCSL is particularly supportive of efforts that provide information about and promote screening for: cardiovascular disease, obesity, asthma, diabetes, cancer. We also support efforts to ensure that children receive age appropriate check-ups and screenings that include recommended childhood immunizations and dental, vision and hearing screenings.
Coverage of cardiovascular screening tests.	<ul style="list-style-type: none"> Provides coverage for screenings for diabetes and cardiovascular disease. (No additional details provided). 	<ul style="list-style-type: none"> NCSL urges Congress to increase support for initiatives that promote regularized preventive health screenings and check-ups. NCSL is particularly supportive of efforts that provide information about and promote screening for: cardiovascular disease, obesity, asthma, diabetes, cancer. We also support efforts to ensure that children receive age appropriate check-ups and screenings that include recommended childhood immunizations and dental, vision and hearing screenings.
Coverage of an Initial Preventive Physical Examination	<ul style="list-style-type: none"> Provides coverage for an initial voluntary physical when becoming eligible for Medicare. 	<ul style="list-style-type: none"> NCSL urges Congress to increase support for initiatives that promote regularized preventive health screenings and check-ups. NCSL is particularly supportive of efforts that provide information about and promote screening for: cardiovascular disease, obesity, asthma, diabetes, cancer. We also support efforts to ensure that children receive age appropriate check-ups and screenings that include recommended childhood immunizations and dental, vision and hearing screenings.

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COMBATTING FRAUD AND ABUSE (PREVIOUS TENTATIVE CONFERENCE AGREEMENT)		
Demonstration Project for the Use of Recovery Audit Contractors	<ul style="list-style-type: none"> ▪ Requires the Secretary to conduct a demonstration project where recovery audit contractors would be paid on a contingency basis to identify underpayments and overpayments and recoup overpayments for both Part A and Part B services. The provision would also permit the money collected by the recovery audit contractors (less their contingency fee) to be made available to the CMS program management account. 	<ul style="list-style-type: none"> ▪ No policy.
DEMONSTRATION PROJECTS		
Medicare Fee-For-Service Care Coordination Demonstration Program.	<ul style="list-style-type: none"> ▪ Establishes a disease management program to assist beneficiaries with chronic illnesses. 	<ul style="list-style-type: none"> ▪ NCSL urges Congress to continue to support initiatives that promote the management of chronic conditions such as obesity, cardiovascular disease, diabetes, asthma, kidney disease and a wide range of autoimmune diseases. Management of these conditions improves the quality of life of the individuals and their families and is more cost efficient for the health care system.
Demonstration Program For Substitute Adult Day Services.	<ul style="list-style-type: none"> ▪ Directs Secretary to conduct a demonstration for home health services delivered at medical adult day care centers. 	<ul style="list-style-type: none"> ▪ No policy.
Extension of Municipal Health Service Demonstration Projects.	<ul style="list-style-type: none"> ▪ Extends the municipal health service demonstrations through 2006. 	<ul style="list-style-type: none"> ▪ No policy.
REGULATORY REFORM		
Overview of Major Provisions	<p>The preliminary agreement reached by the conferees would modernize the Medicare program by simplify the payment process and make it more rational and understandable for both providers and beneficiaries by:</p> <ul style="list-style-type: none"> ▪ Modernizing the contracting system to introduce competition and consolidate contracting in Medicare Parts A and B. Since 1965, only one new contractor has been added to the Medicare program. Competition will bring new technology, new ideas and better service to both providers and beneficiaries; ▪ Creating a beneficiary advocate inside Medicare to help beneficiaries navigate through the confusing morass of Medicare requirements; ▪ Protecting providers from arbitrary and capricious actions that may occur during the auditing process; ▪ Holding the government accountable for the guidance it gives 	<ul style="list-style-type: none"> ▪ No policy.

PROVISION	MEDICARE PRESCRIPTION DRUG CONFERENCE AGREEMENTS	NCSL POLICY
	<p>to providers by prohibiting government sanctions (including interest on overpayments) if a provider follows written, erroneous guidance;</p> <ul style="list-style-type: none"> ▪ Assisting providers in dealing with the complex maze of Medicare rules and regulations by improving provider education and technical assistance; ▪ Prohibiting retroactive application of new regulations; ▪ Strengthening the independence of reviewers in the appeals process; ▪ Establishing a process for beneficiaries and their doctors to find out in advance whether certain items and services are covered by Medicare; and ▪ Ensuring hospitals are paid for emergency services. 	
GENERIC DRUG PROVISIONS		
Over view	<ul style="list-style-type: none"> ▪ The Conference Agreement ends existing loopholes in the Hatch-Waxman law by making changes to the 30 month stay and 180 day provisions. ▪ Under the conference agreement, new drug applicants will receive only one 30-month stay per product for patents submitted prior to the filing of a generic drug application. ▪ In addition, the Conference agreement modifies rules relating to generic company's 180-day exclusivity. Specifically, it enables multiple companies to qualify for the 180 day exclusivity if they all file their application on their first day of eligibility. ▪ Additionally, the conference agreement will contain provisions relating to declaratory judgments, which are designed to accelerate generic company's ability to enter the marketplace. 	<ul style="list-style-type: none"> ▪ No policy.
IMPORTATION OF PRESCRIPTION DRUGS		
General Provisions	<ul style="list-style-type: none"> ▪ Limits drug reimportation to Canada and retains current law requirement that would permit reimportation only if the HHS Secretary certifies that reimportation would pose no additional risk to the public's health and safety.⁹ 	<ul style="list-style-type: none"> ▪ No policy.

⁹ On October 28, 2000, the Congress enacted the Medicine Equity and Drug Safety Act (P.L. 106-387), authorizing the Food and Drug Administration (FDA) to permit the reimportation of certain prescription drug products manufactured in the United States that have been exported to a foreign country. It permitted reimportation from the following countries: Australia, Canada, Israel, Japan,

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	<ul style="list-style-type: none"> ▪ Directs the HHS Secretary to conduct a study on the major safety and trade issues related to reimportation. 	
TAX PROVISIONS		
Health Security Accounts¹⁰	<ul style="list-style-type: none"> ▪ Creates tax-free Health Savings Accounts (HSAs) for qualified medical expenses. ▪ Authorizes Health Savings Accounts (HSAs) to be established by any individuals who purchase a health plan with an annual deductible of at least \$500 for self-coverage or \$1,000 for family coverage. ▪ Unlike the current Medical Savings Account (MSA) law, that is limited to small employers, there are no limits related to the size of the employer. ▪ Employers can also make non-deductible contributions. ▪ Permits up to \$500 in unused flexible spending account funds to be rolled into a Health Savings Account. ▪ Savings can be used for qualified medical expenses. ▪ There are no income-related eligibility requirements. 	<ul style="list-style-type: none"> ▪ No policy.
Tax Treatment of Federal Subsidy to Employers for Retiree Prescription Drug Coverage	<ul style="list-style-type: none"> ▪ Provides that the 28% employer subsidy for retiree prescription drug coverage is excludable from taxable income.¹¹ 	<ul style="list-style-type: none"> ▪ No policy.
Exception to Information Reporting Requirements Related to Certain Health Arrangements	<ul style="list-style-type: none"> ▪ Clarifies that employers do not have to provide 1099 Forms to service providers if services are paid for with a debit, credit, or stored-value card. 	<ul style="list-style-type: none"> ▪ NCSL policy urges Congress to provide the same incentives to state and local governments as are provided to private sector employers.

New Zealand, Switzerland, South Africa, European Union (EU) countries (Austria, Belgium, Denmark, Germany, Greece, Finland, France, Ireland, Italy, Luxembourg, The Netherlands, Portugal, Spain, Sweden, the United Kingdom and any new members of the EU), Iceland, Liechtenstein and Norway. **The law permits the FDA to add countries to the list. The law provides that the reimportation provisions cannot become effective until the Secretary of the U.S. Department of Health and Human Services (HHS), "...demonstrates to the Congress that the implementation of this section will—(1) pose no additional risk to the public's health and safety; and (2) result in a significant reduction in the cost of covered products to the American consumer." To date no HHS secretary has been willing to attest to the safety of reimported prescription drugs.**

¹⁰ Federal law authorizing Medical Savings Accounts (MSAs) will expire next year. Health Savings Accounts (HSAs) were designed to replace and expand the MSA concept.

¹¹ This is an additional incentive to for-profit employers to retain their existing prescription drug coverage for retirees. There is no additional incentive for state and local governments because they have no federal income tax liability.