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MEDICARE FACT SHEET

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**Final Rules Implementing the New Medicare Law:
A New Prescription Drug Benefit for All Medicare Beneficiaries,
Improvements to Medicare Health Plans and Establishing Options for Retirees**

FACTS ABOUT TODAY'S ACTION

The U.S. Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) today issued the final regulations implementing a new prescription drug benefit that will help people with Medicare pay for the drugs they need. This benefit begins in January 2006 and allows all Medicare beneficiaries to sign up for drug coverage through a prescription drug plan or Medicare health plan. The final regulations also provide new protections for retirees who currently receive drug coverage through their employers or unions, and they strengthen the Medicare Advantage program.

To develop the final regulations implementing the Medicare prescription drug benefit, CMS relied on the expertise, input and recommendations from individuals and organizations such as consumer and beneficiary advocates, health plans, pharmacies, pharmaceutical benefit managers, actuaries, states, health care providers, employers, unions, and other affected groups and experts. In addition, thousands of written comments and an extensive series of public meetings, including Open Door Forums, provided CMS with helpful advice and information in response to the proposed regulations that were published in August 2004.

BACKGROUND

For Medicare beneficiaries, two key provisions of the Medicare Modernization Act (MMA) are the new prescription drug benefit and the enhanced health plan choices in Medicare Advantage. As a result of these new benefits, beneficiaries can get prescription drug coverage and new support for their existing drug coverage through health and prescription drug plans that contract with Medicare. They can also access preferred provider organizations (PPOs), the most popular health plan choices for those under age 65 today.

Since Medicare was created in 1965, it has focused on coverage for acute health care services that are useful after people develop medical complications. Yet one-quarter of seniors and people with a disability now in Medicare have no drug coverage, even though prescription drugs are an integral part of modern medicine to prevent diseases and their complications. Millions more face limits and rising costs in the coverage they receive through Medigap, Medicare Advantage, or state Medicaid plans and pharmaceutical assistance plans. Beneficiaries with

retiree coverage are worried about its security, due to the decline in retiree benefits that has occurred over the past decade. With the enactment of the MMA, and the final rules issued today, Medicare looks more like the rest of the American health care delivery system by giving beneficiaries the option of new, subsidized drug coverage, as well as new support to keep their current retiree coverage secure.

In addition to the standard drug benefit with protection against high out-of-pocket costs, available to all beneficiaries with a 75 percent premium subsidy from Medicare, the MMA and the final regulations provide many approaches for beneficiaries to get even more comprehensive coverage for their prescription drug needs. Low-income seniors and people with a disability who have limited means – about a third of all people with Medicare – will have access to comprehensive coverage, with no or limited premiums and deductibles and low or nominal cost-sharing. Medicare beneficiaries with retiree coverage will benefit from a set of options to continue to get prescription drug coverage, including a new retiree drug subsidy as well as options for employers and unions to wrap around Medicare coverage or offer Medicare-subsidized drug coverage themselves.

The substantial additional resources that Medicare provides through the retiree drug subsidy and the various opportunities employers and unions have for providing additional coverage complementing the standard drug benefit will make it easier for employers and unions to provide high quality retiree drug coverage to Medicare-eligible retirees. In addition, states, other individuals, and charitable organizations will be able to contribute towards a beneficiary's out-of-pocket costs and still have those contributions count towards the out-of-pocket spending threshold that triggers the beneficiary's catastrophic drug coverage protection. Beneficiaries who have been paying the full cost for their own drug coverage, either through "access-only" retiree plans (plans where the retiree finances 100 percent of the cost of the premium) or through Medigap policies, will now gain access to a generously subsidized drug benefit that will make coverage more affordable, and will have the option of supplementing the standard Medicare drug benefit.

The new Medicare law and the proposed rules also allow states the flexibility to enhance, or "wrap around," the comprehensive coverage for certain low-income beneficiaries. States will also save money because Medicare will provide comprehensive coverage for "dual-eligible" beneficiaries (those who qualify for Medicaid and Medicare) and provide new subsidies for state retiree coverage.

Beneficiaries also have access to a variety of modern integrated health insurance plans, including preferred provider organizations (PPOs), all with Medicare-subsidized drug coverage. PPOs are the most popular health plans for younger Americans who are covered by commercial health insurance plans, but until now have generally been unavailable to people with Medicare, particularly those in rural areas.

Enhanced Drug Coverage with Savings for Beneficiaries, States, and Employers

The Medicare prescription drug benefit: The final rules describe the plan options that beneficiaries will have to obtain their outpatient drug coverage. Prescription drug plans and Medicare Advantage plans will be required to provide basic coverage, but may also offer additional plans with supplemental coverage. These "high option" plans with enhanced coverage

(for example, with lower cost-sharing) allow beneficiaries to add to the Medicare-subsidized standard coverage using some of the contributions that they, their health plans, employers, unions, and others already make today. Charitable organizations, other individuals, and states will also be able to contribute to beneficiary out-of-pocket costs while still having their contributions count as "true out-of-pocket" spending for purposes of the Medicare subsidy for high drug expenses. A beneficiary's health care spending account, such as a flexible spending account or a health savings account, can also contribute while counting as "true out-of-pocket" spending.

Medicare prescription drug plans will also be required to have cost management programs that lower prescription drug costs for beneficiaries including the use of medication therapy management programs and a coordination of benefits system that will enable multiple payors to be recognized for individual drug claims.

Comprehensive assistance for low-income beneficiaries: CMS estimates that nearly 11 million beneficiaries with limited means will receive substantial additional help from Medicare. In addition to the 75 percent subsidy for the standard Part D benefit provided to all Part D enrollees, low-income beneficiaries will receive additional premium and cost-sharing subsidies averaging almost $2300 per person in 2006**.**

- About 6.3 million low-income beneficiaries who are full-benefit dually eligible for both Medicare and Medicaid will have no premium or deductible and co-pays of as little as $1 or $3 per prescription. For these beneficiaries, the Medicare benefit will pay, on average, 98 percent of their drug costs.

- About 3 million Medicare beneficiaries who are not full benefit dual-eligible beneficiaries, but whose incomes are less than 135 percent of the federal poverty level (in 2004, $12,569 for an individual and $16,862 for a couple) and with limited assets, will also pay only a few dollars per prescription. Medicare will cover 96 percent of their drug costs on average.

- For about 1.6 million beneficiaries with incomes less than 150 percent of the federal poverty level and assets up to $10,000 (or $20,000 if married) in 2006, the Medicare benefit will provide 15 percent co-pays with a sliding-scale premium, covering on average 85 percent of their drug costs.

- The new comprehensive drug benefit is also expected to attract more than 1 million beneficiaries with limited means who have been eligible but have not previously enrolled in Medicaid benefits (including Qualified Medicare Beneficiary and Specified Low-income Medicare Beneficiary benefits – QMB and SLMB) because of the high value of the drug benefit and Medicare's unprecedented outreach activities.

The final rules ensure that the most vulnerable of low-income beneficiaries, many of whom are nursing home residents, who do not sign up for a drug plan by the middle of December will be auto-enrolled by Medicare to further ensure there is no gap in coverage. Beneficiaries who are identified as full benefit dual-eligibles will be notified of their entitlement to drug coverage and will be auto-assigned to a drug plan in their area. The final rules also describe the process for

protecting low-income beneficiaries transitioning their drug coverage from their state to Medicare by detailing a three-part strategy that includes formulary review criteria for certain diseases, medical necessity coverage of non-formulary drugs, and plan-specific transition procedures to further ensure that dual-eligible beneficiaries will get the drugs they need. CMS may also facilitate the enrollment of individuals who are determined eligible for the low-income subsidy.

The straightforward means test proposed in the rules means that about a third of all Medicare beneficiaries would be eligible for low-income assistance with no or limited premiums and deductibles and low or nominal cost-sharing. For example, beneficiaries with incomes below 135 percent of the federal poverty level and meeting the asset test can get a lifesaving drug that costs $40,000 or more annually for no more than $60 per year.

The final rules state that the asset test will only count liquid assets and real estate holdings other than a beneficiary's home or residential farm – non-liquid assets such as wedding rings, family heirlooms, and burial plots will not be counted. The rules outline new methods for collaboration with the Social Security Administration, states and non-governmental organizations that work with Medicare beneficiaries with limited means to enroll as many eligible beneficiaries as possible. About a third of all Medicare beneficiaries and about half of minority beneficiaries will qualify for these very comprehensive benefits, which mean no gaps in coverage.

Assuring that nursing home residents will be able to enroll in a Medicare drug plan and continue to get the drugs their doctors say they need: Based on extensive consultations with nursing homes, specialized long term care pharmacies, and others (including an "Open Door Forum" on this topic), the approach for providing Part D coverage for nursing home residents creates strong incentives for prescription drug plans to contract with most long term care pharmacies in an area, and most of these pharmacies will be able to contract with many plans.

Drug coverage is available for all beneficiaries: Prescription drug plans and Medicare Advantage plans will offer Medicare beneficiaries help in purchasing their prescription drugs. The standard drug benefit in 2006 will pay on average 75 percent of drug costs after a $250 deductible, up to an initial coverage limit of $2,250, and will pay about 95 percent of the beneficiary's drug costs once the beneficiary spends $3,600 out-of-pocket.

There is no annual plan maximum, and that coverage will never run out. On average, beneficiaries will receive a 75 percent subsidy on the premium for this coverage, resulting in a cost, on average, of less than $37 a month in 2006. Medicare will pay about $113 a month per beneficiary toward the cost of drug coverage. For beneficiaries with standard coverage and who are not eligible for the low-income subsidies, the drug benefit will pay on average about half of their drug costs. The savings for the standard drug benefit come from two main sources:

- The prescription drug and Medicare Advantage plans will use their experience in negotiating discounted prices and managing prescription drugs costs to guarantee that seniors and people with disabilities will pay the lowest prices available for the drugs they need. The new drug benefit is expected to provide beneficiaries with drug cost savings of 15 percent initially, rising to 23 percent within 5 years. These estimated cost savings come because strong competitive pressures, including transparency in drug price and benefit information, that drug

plans will have to negotiate discounted prices and manage drug costs to obtain the lowest costs possible while providing the drugs that beneficiaries need, and to pass these savings on to beneficiaries. This approach is similar to the one used by the Federal Employees Health Benefits Program and other large health care payers. With the steps outlined in the final rules, beneficiaries will be paying even less for their prescription drugs.

- The final rules establish a competitive process for getting low premiums, low drug prices, and high-quality pharmacy services for Medicare beneficiaries so that they have access to high-quality prescription drug plans at lower prices than they currently pay. The process includes direct Medicare oversight to make sure that the costs and quality of plan "bids" are reasonable. Medicare will also make it easier for beneficiaries to do "comparison shopping" by providing specific, personalized information on premiums, covered drugs and their prices, pharmacies and pharmacy services, and other important features of drug plans.

The final rules assure that beneficiaries will be covered for medically necessary drugs at their neighborhood pharmacies. Drug plans are required to follow the existing beneficiary protections that are available in Medicare and to meet strict pharmacy access standards. The final rules also outline the process for beneficiaries to get a drug that is not on the formulary when a physician determines that it would be in the best interest of the patient to have that drug. This process assures that urgently needed drugs will be covered while the exception process is concluded.

Beneficiary Protections under the new prescription drug benefit: The final rules also describe protections to make sure that beneficiaries have coverage for medically necessary drugs through nearby pharmacies.

Prescription drug plans would be subject to many of the existing beneficiary protections that are available in Medicare, as well as some new ones, including requirements to meet strict pharmacy access standards to give beneficiaries access to retail pharmacies and needed drugs.

The final rules also describe how the drug benefit will build on the transparent pricing and drug coverage features of the Medicare-approved drug discount card program, with the goal of making sure that beneficiaries see the specific, personalized information they may want about a plan's prices, formularies (specific covered drugs), and information about local pharmacies.

The rule also outlines approaches to assure beneficiaries will be able to get the drugs they need through drug formulary standards and oversight. When possible, plans will be required to include multiple drugs in every therapeutic category on their formularies. Plans must encourage the use of generic drugs by requiring provision of information on lower cost generic substitutions (if available) at the point of sale. Plans must also use a pharmacy and therapeutics committee including practicing doctors and pharmacists to establish a formulary, so plan enrollees can be assured that they have access to the most up-to-date drugs possible.

In addition, urgently needed drugs would be covered while a prompt exception process is completed. A physician or an authorized representative, such as a family member or caregiver, can help a beneficiary in the appeals process.

Plans offering the new Medicare drug benefit will also be required to have a program to make sure beneficiaries receive the appropriate drugs to improve their health outcomes and reduce adverse drug interactions. Plans will be required to supply a range of information to beneficiaries, including a clear explanation of the benefits and periodic status reports on other prescription drug spending; a description of the function of any formulary; useful information about how the use of generic drugs can help to lower drugs costs even more; how the plan's medication management program works; and information on grievance and appeals processes.

Plans must also maintain beneficiary privacy and confidentiality, and conduct surveys on customer satisfaction.

Example: Drug Benefit Savings for a Beneficiary With $2400 in Drug Spending

Beneficiary Group	**Annual Spending**	**Out-of-pocket Spending Under Part D**	**Percentage Savings After Premium**	**Dollar Savings After Premium**
Beneficiary with standard coverage with incomes at or above 150% of FPL	$ 2400	$ 697.50	53%	$1,262.50
Beneficiary with income under 150% FPL and low assets	$ 2400	$ 348.50	77%	$1,831.50
Beneficiary with income below 135% FPL and low assets or beneficiary dually eligible for Medicaid above 100% FPL regardless of assets	$ 2400	$ 109.85	95%	$2,290.00
Beneficiary dually eligible for Medicaid with income at or below 100% FPL	$ 2400	$ 62.77	97%	$2,337.23
Beneficiary who is dually eligible for Medicaid and a nursing home resident	$ 2400	$ 0	100%	$2,400.00

Explanatory Notes: $2400 is close to the projected median spending for all beneficiaries in 2006. Beneficiary out-of-pocket and percentage savings assume 15% cost management savings by Part D plans, through price discounts and utilization management. Premium for the 150% FPL group is assumed to be in the middle of the sliding scale between $0 and $440. The out-of-pocket calculation for the 135% FPL and 100% groups assumes an average prescription price of $65 and an average co-pay of $3.50 and $2, respectively. The "percentage savings after premium" column differs from other numbers presented in the text because it reflects an individual case and includes premium, whereas the text represents average coverage across the various income groups and does not include premium.

Example: Medicare Coverage for a Beneficiary With Annual Spending of $10,000

Beneficiary Group	Annual Spending (Unmanaged, Full Retail)	Out-of-pocket Spending Under Part D	Percentage Savings After Premium	Dollar Savings After Premium
Beneficiary with standard coverage at or above 150% FPL	$10,000	$3,770.00	58%	$5,790
Beneficiary with income under 150% FPL and low assets	$10,000	$990.58	88%	$8789.42
Beneficiary with income below 135% FPL and low assets or beneficiary dually eligible for Medicaid above 100% FPL regardless of assets	$10,000	$274.62	97%	$9725.38
Beneficiary dually eligible for Medicaid with income at or below 100% FPL	$10,000	$156.92	98%	$9843.08
Beneficiary who is dually eligible for Medicaid and a nursing home resident	$10,000	$0	100%	$10,000

Explanatory Notes: Beneficiary out-of-pocket and percentage savings assume 15% cost management by Part D plans, through price discounts and utilization management. Premium for the 150% FPL group is assumed to be in the middle of the sliding scale between $0 and $440. The out-of-pocket calculation for the 135% FPL and 100% groups assumes an average prescription price of $65 and an average co-pay of $3.50 and $2, respectively. The "percentage savings after premium" column differs from other numbers presented in the text because it reflects an individual case of a very high spending beneficiary and includes premium, whereas the text represents average coverage across the various income groups and does not include premium.

Support for retiree drug coverage plans to ensure beneficiaries will be able to keep the coverage they have: Many employers and unions have dropped retiree drug coverage over the past decade, and the new Medicare law provides the first real effort by the federal government to change this trend and to preserve employer and union-sponsored retiree drug coverage. The Medicare

prescription drug benefit and the retiree subsidy is expected to significantly lower employers' and unions' cost of providing drug coverage, making the provision of high-quality coverage much more affordable to the employer or union and thus, more likely.

- The new rules give employers and unions a menu of options enabling them to continue subsidizing high quality drug coverage for their retirees.

  - One option provides sponsors of retiree drug coverage with federal subsidies of 28 percent of incurred allowable drug costs between $250 and $5,000 in 2006 for each qualifying covered retiree.
  - The rule also provides other approaches for employers to supplement the Medicare drug benefit, including:
    - providing supplemental drug coverage that wraps around a prescription drug plan (similar to policies that wrap around Medicare benefits under Part A and Part B),
    - providing an employer-sponsored Medicare Advantage or Part D plan to provide enhanced benefits to their retirees, either by contracting with a Part D plan or choosing to become a drug plan that offers enhanced benefits to their retirees.

- Additional protections help ensure that employers will not receive a "windfall" – a payment higher than the employer's contribution to retiree coverage.

The implementation of the Medicare prescription drug benefit, including the Medicare retiree drug subsidy and other opportunities employers and unions have to provide continued prescription drug assistance to their Medicare retirees, will result in combined aggregate payments by employers/unions and Medicare for drug coverage on behalf of retirees that are significantly greater than they otherwise would have been without the enactment of the MMA – that is, the financial assistance that retirees receive for their drug costs will go up substantially.

Large savings in drug costs for rural beneficiaries: The new drug benefit is particularly important for one out of four Medicare beneficiaries who live in rural areas. These beneficiaries are less likely to have drug coverage from retiree plans or other sources. In addition, many rural beneficiaries have limited incomes and assets. At least two new Medicare drug plans are guaranteed to be available in rural areas. The prescription drug plans will serve entire regions, and the proposed rule includes a guaranteed "fallback" program to further ensure that every Medicare beneficiary across the country has access to prescription drug coverage.

Savings for states: States are projected to net savings of about $1 billion in 2006 and approximately $8 billion in the first five years of the drug benefit. The sources of savings include:

- *Medicare drug coverage for dual eligibles:* Starting in 2006, full-benefit dual eligible beneficiaries (Medicare beneficiaries eligible for a state's full range of Medicaid benefits, including drug coverage) will receive prescription drug coverage through Medicare rather than through their state Medicaid programs.
- *State Savings on Drug Costs for Retired State Workers:* As employers, states can qualify for the new retiree drug subsidies available to employers and unions that furnish qualified retiree drug coverage to Medicare beneficiaries, or states can choose among the other options available to employers for providing continued prescription drug assistance to their Medicare retirees.

- *Relief for State Pharmaceutical Assistance Programs:* States that operate State Pharmaceutical Assistance Programs (SPAPs) providing subsidized drug coverage to individuals who will be eligible for the Medicare prescription drug plan will save

substantially starting in 2006, when Medicare begins providing very generous coverage for beneficiaries with limited means. As a result of the savings on beneficiaries who qualify for the low-income Medicare coverage, states can "wrap-around" the Medicare benefit to maintain or enhance benefits, at a lower cost to the state. States with "Pharmacy Plus" programs can also take advantage of the new benefit by using their financial contributions to wrap around the new Medicare coverage.

Because states will no longer have to pay for drug coverage for full-benefit dual eligibles, states will be required to make payments to the federal government to defray a portion of the Medicare drug expenditures for these beneficiaries. States save because their payments are based on the costs that each state has actually incurred to provide drug coverage – that is, they only have to pay a fraction of their previous drug costs for dual eligible beneficiaries, trended forward. States will also incur some new administrative costs, though the Social Security Administration expects to play a substantial role in the low-income eligibility determination process thus helping to reduce state burdens. The new drug coverage and outreach are also expected to increase Medicaid enrollment. The estimates of net savings for states take all these factors into account.

Availability of more health plan choices that help beneficiaries save money: The final rules increase the availability of coordinated-care health plans through Medicare Advantage plans that allow beneficiaries to lower their out-of-pocket costs significantly. The savings are possible because the plans generally offer lower cost-sharing as well as additional benefits – including coverage for additional preventive services, disease and care management services, and other services like dental and vision – that are not available in fee-for-service Medicare. As a result, beneficiaries enrolled in Medicare Advantage plans can obtain substantial savings in out-of-pocket costs compared to the traditional fee-for-service Medicare plan.

Access to coordinated care plans has increased significantly in recent years, after five years of declines between 1998 and 2003. In 2003, 59 percent of Medicare beneficiaries had access to a coordinated care plan. In 2004, that rose to 61 percent and at the beginning of 2005 stood at 65 percent. Looking at both coordinated care plans and Medicare private fee-for-service plans, as of early 2005, more than 80 percent of Medicare beneficiaries have access to at least one Medicare Advantage plan in their area.

A recent CMS study indicates that in 2004, beneficiaries in Medicare Advantage program paid about $700 less a year in out-of-pocket medical costs, and beneficiaries in fair or poor health paid as much as $1,900. Other studies have also found substantially lower out-of-pocket costs because of greater benefits and reduced cost sharing. The Medicare Advantage reforms are expected to increase the opportunities for lower cost sharing and improved benefits in coordinated care plans.

Medicare Advantage plans have also been especially popular for beneficiaries with limited means, and the new Medicare health plans available as a result of the regulations will allow many more beneficiaries to save in this way if they choose.

Beneficiaries who choose to enroll in a Medicare Advantage plan will be able to get subsidized drug benefits as part of their overall health plan, allowing the plans to better coordinate beneficiaries' medical care and drug coverage.

Expanding health plan choices with regional PPO and specialized Medicare Advantage plans: The rules create a new regional Medicare Advantage PPO contracting option as an additional plan choice for Medicare beneficiaries beginning on Jan. 1, 2006. PPOs are the most popular health insurance choice for millions of working Americans, including those living in rural areas, in part because they offer both low co-payment rates for "network" services as well as coverage for "non-network" care received from any provider. Unlike the current Medicare Advantage program, which features local plans that serve individual counties and groups of counties, the new regional PPOs will serve one, several or all 26 regions across the U.S., which cover all rural areas. Plans may offer a PPO in more than one region or in all regions. The goal of these larger regional markets is to have more plan options in rural areas by grouping them with the urban areas that have traditionally attracted managed care plans under the Medicare + Choice program.

All of regional PPO plans are required to offer the same benefits as traditional fee-for-service Medicare with simplified cost-sharing and new protections against catastrophic costs. They are also expected to offer additional benefits not available in fee-for-service Medicare.

The rule also supports the creation of plans to offer health care services to beneficiaries with special needs, such as those who are Medicaid eligible, those with severe or disabling chronic conditions, and those who live in nursing homes and other long term care institutions. Indeed, some special needs plans have already entered the Medicare program.

Competitive Bidding for Health Plans for Part A and B Benefits. The regional PPOs, which must serve all of a CMS-designated region, and the local Medicare Advantage plans, which cover single or multi-county areas, will be using the same new competitive bidding process for determining payment for Part A and B benefits.

Plans will submit bids for how much it would cost them to provide medical benefits to a "typical" beneficiary in the region or service area, where a typical beneficiary has the statistical average age and health status for Medicare beneficiaries in the nation. Medicare payments to a plan will depend on the benchmark determined by the competitive bidding process. The Medicare benchmark for local and regional plans is the most that Medicare will pay for Medicare Part A and Part B services. The Medicare benchmark for regional plans is based on a model that blends the current administered pricing system for local plans with an average of regional plan bids for the typical beneficiary in that region. The Medicare benchmark for local plans remains the same. For all plans with bids that are less than the benchmark, the beneficiary gets three-fourths of the difference in the form of lower premiums or cost sharing or additional benefits, and the government retains one-fourth. For all plans with bids that are higher than the benchmark, beneficiaries pay the difference in the form of a premium. Consequently, more efficient plans can attract beneficiaries through lower premiums or alternatively, they can use the savings to offer additional benefits.

In setting the benchmarks, the rule includes the changes under the MMA to provide more accurate and fair Medicare Advantage county capitation rates in many counties. The new funding is expected to help ensure that Medicare beneficiaries who count on Medicare

Advantage plans will have reliable access to them, and consequently to the additional benefits and significantly lower out-of-pocket costs generally provided by these plans. The payment rates for 2005, announced in May 2004, have brought additional Medicare Advantage plans into more

markets serving more Medicare beneficiaries, so that more have access to lower-cost, higher-benefit coverage options.

By enhancing the use of risk adjustment methods to pay health plans, CMS intends to concentrate new Medicare Advantage funding on beneficiaries who are expected to need it the most based on their health status, ensuring that regardless of beneficiaries' specific health status, they will benefit from the wide range of available choices. CMS is refining the risk adjustment methodology currently used to pay Medicare Advantage plans to improve its ability to provide higher payments for beneficiaries with complex conditions. CMS is also working on developing a risk adjustment payment methodology for the new drug benefit plans.

Medigap Options and Supplemental Coverage: While Medigap policies with drug coverage will no longer be issued to new subscribers after January 1, 2006, Medigap insurers will be able to continue to supplement Medicare's Part A and Part B benefits for beneficiaries. Beneficiaries who have existing drug coverage under a Medigap plan will be able to continue that coverage. However, these beneficiaries would pay the full cost of the premium for Medigap drug coverage (often more than $120 a month for the drug coverage portion of the Medigap plan, compared to the estimated average of less than $37 for the monthly drug benefit premium). The standard Medigap plans offer only limited drug coverage with no catastrophic protection, and beneficiaries would have to pay more if they enroll in a Medicare prescription drug plan after the initial six-month open enrollment period. So it is likely to be much more advantageous for beneficiaries to enroll in the subsidized, more generous Medicare prescription drug plan. The MMA also provides for two new lower cost Medigap options for supplementing Medicare Part A and Part B services.

Beneficiaries who enroll in a prescription drug plan may also be able to purchase expanded or supplemental drug coverage from a prescription drug plan or Medicare Advantage plan in addition to Medicare's basic coverage. To meet the requirement of providing basic coverage, Medicare Advantage plans can either offer a basic plan or offer an enhanced plan with no additional premium. A Medicare Advantage organization that offers a plan that includes supplemental coverage at no additional cost also may offer other "higher option" plans that offer supplemental coverage at an additional cost.

Electronic Prescribing. To lower drug costs and improve quality, the proposed rules require drug plans to support electronic prescribing, and CMS intends to accelerate the implementation of electronic prescribing through the Medicare drug benefit. CMS expects to issue proposed regulations related to electronic prescribing standards that have broad support, and identify promising e-prescribing pilot programs. CMS is seeking comment on ways to accelerate the adoption of e-prescribing further, and to reduce costs by adopting e-prescribing, as well as comments on how Medicare electronic prescribing can further national health IT goals.

Quality Improvement. By 2006, each Medicare Advantage plan (other than a Medicare Advantage private fee-for-service plan or an MSA plan) will be required to have ongoing chronic care and quality improvement programs. As part of these programs, both local and regional

Medicare Advantage plans are required to provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other quality indicators.

As discussed above, with respect to quality, prescription drug plans and Medicare Advantage plans will be required to establish pharmacy and therapeutics committees that include practicing pharmacists, physicians and an expert in geriatric care. The committees will use the best scientific evidence on the safety, efficacy and side effects of drugs to enhance the quality of the drug plans while controlling costs for beneficiaries.

More Personalized Assistance to Help Beneficiaries Get the Most Out of the New Benefits

CMS is increasing its efforts to provide information to beneficiaries to help them get the personalized assistance they need to get the most out of Medicare's expanded benefits and increasingly modern, but complex health care system. CMS will initiate an integrated and multi-pronged education effort that will include print materials and direct mail, Medicare's consumer information resources including 1-800-MEDICARE and www.medicare.gov, and extensive community-based outreach through a broad array of partners.

Print materials will include simple language fact sheets and more detailed publications including the annual *Medicare & You* handbook, and other direct mail pieces to help beneficiaries learn about Medicare's new benefits. These publications will also be available at Medicare's consumer website, www.medicare.gov.

The 1-800-MEDICARE helpline and www.medicare.gov will answer questions to help beneficiaries understand the new Medicare benefits and learn how to get the most out of these benefits. At 1-800-MEDICARE, CMS has increased the number of customer service operators as of June 2004 and expects to maintain an expanded capacity to handle the unprecedented number of callers in a timely and effective manner. CMS has added voice messages to help callers be better prepared when they reach a customer service representative, further reducing call waiting and call handling time.

Medicare's community-based outreach will work through the Social Security Administration (SSA) and other federal agencies, States, employers, providers, pharmacists and other health care stakeholders and is designed to reach beneficiaries through the various networks where they obtain health care information. For example, SSA will engage in an expansive beneficiary outreach campaign in cooperation with CMS and the States to process low-income subsidy applications for the new prescription drug benefit.

For beneficiaries who require or prefer one-on-one personalized assistance, CMS has also enhanced its partnership with the State Health Insurance Assistance Programs (SHIPs) and with community organizations and beneficiary advocacy groups. HHS awarded $21.1 million in fiscal year 2004 and will award another $31.7 million in fiscal year 2005 to the SHIPs, thereby reflecting the increased emphasis on one-on-one advice and counseling for Medicare beneficiaries. The SHIPs are among the most effective resources in helping beneficiaries learn about the changes to Medicare and will be able to use the additional funds to equip local organizations with the tools needed to answer beneficiaries' questions. CMS is also supporting non-profit organizations to help educate and assist low-income beneficiaries who may otherwise be hard to reach. For example, the CMS partnership with the Access to Benefits Coalition – a collaboration of over 90 patient, consumer, and senior advocacy and support organizations – will provide personalized assistance from familiar sources to many beneficiaries.

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