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MEDICARE FACT SHEET

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PRINCIPAL CHANGES IN NEW MEDICARE FROM PROPOSED RULES TO FINAL RULES
New Rules Establish New Prescription Drug Benefit, Improvements to Medicare Health Plans and Options for Retirees

The final regulations for the Medicare prescription drug benefit, Medicare Advantage and retiree options include a set of changes based on input and recommendations received during the public comment process following the issuance of the proposed rules.

After the proposed regulations were published in August 2004, CMS held an extensive series of public meetings, including many Open Door Forums, outreach meetings, participation in conferences, and other opportunities to receive input and recommendations from a wide variety of individuals and organizations. This input came from beneficiaries and beneficiary advocates, health plans, pharmacies, pharmaceutical benefit managers, actuaries, states, health care providers, and other affected groups and experts. In addition, we received over 7,500 comments from individuals and organizations.

The advice and information gathered at those meetings and in written comments led to important refinements and clarifications from the proposed rules, to help ensure that Medicare beneficiaries will have access to the best drug coverage at the lowest cost possible.

More Sources of Financial Assistance For Beneficiary Coverage

- Other Sources of Assistance with Drug Costs -- CMS has interpreted the statutory requirement broadly so several additional kinds of charity payments can count toward the true out-of-pocket spending needed before catastrophic coverage begins. In addition to charitable and state contributions, these sources include:
  - Waiver of copayments by pharmacies, based on need and circumstances of individual patients
  - Payments from Health Savings Accounts and other tax-favored accounts for health care spending

More Protections for Access to Pharmacies and Medically Necessary Drugs

- Access to Pharmacies -- CMS made several improvements to assure beneficiaries have access to convenient pharmacies, including applying the pharmacy access standard on a state-by-state basis rather than a region-wide basis, allowing certain non-retail pharmacies such as those in Federally Qualified Health Centers to serve as network

providers, allowing "any willing pharmacy" to join a network under standard contract terms, and making it easier for beneficiaries to get drugs from pharmacies that are not in a plan's network.

- Requirements for Up-to-Date Formulary -- The new rules will ensure that beneficiaries will get the drugs they need, while allowing plans the flexibility to provide needed drugs at the lowest possible cost. Based on comments received on the proposed rule and the proposed formulary guidance, CMS modified pharmacy and therapeutics committee membership requirements, the processes to ensure that beneficiaries will be able to get drugs that might not be among the plan's preferred drugs in a timely manner, and to make sure that the formulary will not exclude access to drugs that would discriminate against beneficiaries with certain illnesses. This set of checks and oversight activities will give Medicare beneficiaries broad access to the types of coverage that are already providing effective benefits to millions of seniors and people with disabilities.
- Exceptions and Appeals -- In response to comments received on the proposed rule, CMS significantly shortened timeframes for plans to make coverage determinations and appeal decisions so enrollees will be able to receive the medications their doctors order as soon as possible. Specifically, enrollees will receive decisions about their needed medications in less than 72 hours and even faster, in less than 24 hours, for expedited requests. These shortened response times will avoid beneficiaries having to pay out-of-pocket for their medications while they are awaiting appeal decisions. CMS also amended the rule to allow a physician or an authorized representative, such as a family member or caregiver, to help a beneficiary in the appeals process.
- Emergency Access -- CMS refined emergency access standards so beneficiaries can get access to a reasonable supply of prescribed drugs in urgent situations. Plans will have to ensure adequate access to non-network pharmacies when network pharmacies are not available.
- Reducing Medication Errors and Helping Seniors Get the Most Effective Drugs -- CMS refined the standards for identifying any medication errors and conducting utilization review of drugs. CMS expects to publish a proposed rule regarding e-prescribing standards, implementing the standards before 2006 through large-scale pilot programs. E-prescribing and other steps to improve quality and evidence offer great opportunities to help health professionals provide the best possible guidance to seniors about their drug coverage.

Facilitating the Effective Operation of Drug Plans

- Risk Adjustment -- CMS developed a method for risk adjustment of drug plan payments to ensure that sicker patients are able to enroll in the plan of their choice by paying plans appropriately for providing drug coverage to sicker beneficiaries. These risk adjusters will account for differences in expected drug costs to plans based on patient demographics, chronic diseases, low-income status, and institutional status. CMS has been obtaining public input to refine the risk adjusters and will provide additional guidance on the specific adjustments in the near future.
- Facilitating Claims Payments -- CMS is responding to concerns over how to track spending and sources of drug claims payments by procuring a contract or contracts for True Out-Of-Pocket (TrOOP) cost coordination. This effort will build on existing electronic prescription transaction systems and reflects input from key stakeholders.

- Information on Medigap Drug Coverage -- The final rules note that Medicare will issue a simplified model notice that Medigap plans may use to inform their enrollees about the drug plan options available to them. The notice is important, because the new Medicare drug coverage will generally be substantially less costly than current Medigap drug coverage. This notice will be published soon.

Pharmacy Issues

- Drug Benefit in Long Term Care Pharmacies -- Nursing home residents do not generally obtain drugs directly from pharmacies and they often require specialized dispensing services. Consequently, providing drug coverage in nursing homes requires special attention to this unique setting of care. After publication of the draft rule, CMS had extensive consultations with nursing homes, associations representing residents, and specialized long-term care pharmacies, and other stakeholders, resulting in the framework for providing prescription drugs to nursing home residents in the final rule:
    - Medicare will implement a set of "any willing pharmacy" standards for long term care pharmacy services, which will be based on widely used best practices and will be refined with public input. LTC pharmacies must meet or exceed these standards to provide Medicare drug coverage.
    - Medicare prescription drug plans will have incentives to contract broadly with long term care pharmacies that meet these standards, to obtain the most favorable negotiating position with manufacturers and to be an attractive coverage option to the largest number of beneficiaries.
    - Similarly, most long-term care pharmacies will have a strong competitive incentive to contract with as many plans as possible, in order to serve the largest number of beneficiaries possible.
    - Medicare will help provide information such as plan participation of pharmacies to the operators of long term care facilities, so that they can select a pharmacy or pharmacies that will serve their long term care residents. Medicare will also provide plan information to nursing home residents and their representatives, to help them obtain the coverage that best meets their needs.
    - Medicare will risk adjust payments in the drug benefit to account for the potentially higher cost of serving long term care residents.
    - Payments for services not directly related to the pharmacy dispensing of LTC drugs, such as drug administration, will be handled through separate competitive contracts (long term care pharmacies that provide these related services can continue to do so, but nursing homes will have the opportunity to obtain them from other competitive sources).
    - Together, these steps will lower prices (by using the negotiating power of large pharmacy benefit managers on behalf of large numbers of nursing home residents, and by promoting price competition among plans and their pharmacies) and assure high-quality services (by promoting competition to meet or exceed the LTC "best practice" standards). This competitive approach includes opportunities for smaller pharmacies to participate, while accommodating the need for nursing homes to deal with one or at most a few pharmacies in serving their patients.
- Resolving Coverage Questions -- CMS clarified that prescription drug plans and Medicare Advantage plans, not participating pharmacies, are responsible for coverage

- decisions. Pharmacies will provide standardized notices to help enrollees obtain quick answers from their plans if there are problems with coverage or prices.
- Medication Therapy Management -- Comments on medication therapy management tools varied widely, indicating a need for flexibility and for support to develop better evidence on particular approaches that work. CMS plans to use its guidance authority to specify medication therapy management tools as additional best practices. CMS is also implementing pilot programs involving medication therapy management, including the chronic care improvement program this year, and intends to expand the use of programs that are demonstrated to be effective.

Achieving Greatest Possible Increases in Support for Retiree Coverage
The retiree drug subsidy is designed to encourage employers and unions to continue providing high quality prescription drug coverage. It has highly flexible rules that permit employers and unions to continue providing drug coverage to their Medicare-eligible retirees at a lower cost while retaining their current plan designs that are at least equivalent to the value of the defined standard Medicare drug benefit. The retiree drug subsidy will pay 28 percent of retiree's drug costs (as defined by the regulation) between $250 and $5000 in 2006. The subsidy only applies to retirees eligible for but not enrolled in a prescription drug plan. The payments are tax-free, which increases their value to plan sponsors that are subject to taxation. To qualify for the subsidy, the plan sponsor must show that its coverage is as good as, or better than, Medicare's standard prescription drug benefit. The final regulations include a two-part test for plan sponsors to determine whether this standard, referred to as "actuarial equivalence," has been met.

- Because Medicare payments must be directed to support retiree coverage, this standard prevents employer windfalls. It is feasible for employers and unions to implement.
- CMS is providing a set of simple calculation methods for actuarial equivalence to allow the great majority of employers to demonstrate that they qualify.
- CMS also provided flexibility to the employers and unions in applying the actuarial equivalence standard on an aggregate basis when they have several plans with different benefit options and designs, provided that each of the benefit options meets the "gross value test" of being at least as comprehensive as the Medicare drug benefit.

Employers who use the retiree drug subsidy will be able to offer high-quality retiree coverage at a much lower cost. The final rule estimates that in 2006 plan sponsors that choose to participate in the retiree drug subsidy program will receive $668 on average in annual per capita retiree subsidy payments. For plan sponsors subject to taxation, we estimate that the $668 tax-free retiree drug subsidy would be equivalent to about $891 of taxable income for employers with a marginal tax rate of 25 percent and about $1,028 of taxable income for employers with a marginal tax rate of 35 percent.

In addition, the final rules, taking comments about the draft rule into consideration, establish three different processes to pay employers who qualify for the retiree drug subsidy -- monthly, quarterly, or annually.

***Overview of Additional Plan Sponsor Options*:** In addition to the retiree drug subsidy, another option available to plan sponsors is to encourage their retirees to enroll in a Medicare Prescription Drug Plan or Medicare Advantage plan that includes prescription drugs (collectively, "Part D plans"), while opting to provide them with extra help. There are several

ways that employer and union plan sponsors could supplement the standard Medicare drug benefit:

- They can set up their own separate supplemental plans and coordinate benefits with the coverage offered by prescription drug benefit plans their retirees enroll in to provide extra help with cost sharing in much the same way they currently supplement the standard Medicare Part A and B benefits.

- They can pay for enhanced coverage through a drug plan to subsidize more of their retirees' cost-sharing and provide additional benefits. CMS plans to use its waiver authority to allow sponsors to make special arrangements with drug plans for, or offer their own drug plans to, their retirees. These waivers would allow employers to provide more flexible benefits and to limit enrollment to their retirees.

  CMS estimates that in 2006 plan sponsors that choose to offer comprehensive drug coverage by wrapping around or enhancing the prescription drug benefit will achieve cost savings of at least $900 on average due to the Federal government subsidizing a significant portion of the cost of the standard drug benefit coverage.

- Regardless of whether they choose to provide additional coverage that supplements the standard Medicare prescription drug coverage, plan sponsors can also provide other types of financial help, such as assisting their retirees in paying for some or all of their prescription drug benefit premiums or contributing to a tax-favored account for medical expenses.

Compared to previous estimates, CMS expects that a much larger number of beneficiaries will receive comprehensive coverage either through a retiree plan that qualifies for the retiree drug subsidy or through one of the other options available to employers to add to the standard Medicare drug benefit. These estimates reflect the favorable response CMS received from employers and unions related to the retiree drug subsidy program and other options for providing comprehensive coverage, the findings from recent employer surveys which suggest that many employers are planning to use one or more of these methods to provide comprehensive coverage, and the additional flexibility that the final rule provides for employers/unions while avoiding windfalls.

For example, in 2006, about 9.8 million beneficiaries will receive prescription drug coverage from an employer or union-sponsored retiree plan that is eligible for the retiree drug subsidy. This estimate, which reflects CMS' assumptions regarding employers' and unions' response to its final "two-prong" actuarial equivalence standard, is more than one million people above the highest previous estimates. In addition, CMS expects that a growing number of employers and unions will provide lower-cost comprehensive coverage by taking advantage of the opportunity to "wrap around" the Medicare prescription drug benefit, as they do today for Part A and Part B benefits - up to 2.4 million by 2010. Recent surveys have shown interest on the part of employers in other approaches for providing comprehensive coverage as well, including through a customized Medicare drug or Medicare Advantage plan.

It also is important to note that many employers now make little or no contribution toward the cost of retiree health insurance coverage. A recent employer survey found that nearly 20 percent of large firms require new Medicare-age retirees to pay 100 percent of the premium for retiree health insurance. Another 11 percent require these retirees to pay 61 to 99 percent of the premium. Such coverage generally would not be eligible for the retiree drug subsidy, because of the "two-prong" test designed to prevent windfalls to employers. However, retirees who have drug coverage with little or no subsidy today will now have access to Medicare's drug benefit with a 75 percent subsidy, giving them much more financial support for their drug costs than they receive today. The share of retirees with little or no employer subsidy who may be substantially better off financially in the subsidized Medicare drug benefit is expected to rise in the future, so that a growing number of retirees would benefit from moving to Medicare drug coverage.

Recent surveys show that new retirees are significantly more likely to have "access only" retiree coverage, that is, coverage in which the employer makes no financial contribution. Finally, for many retirees who move to Medicare drug plans, employers are expected to provide either premium assistance or other financial assistance (e.g., account-based arrangements that defray out-of-pocket expenses). Thus, many of the retirees who move to Medicare drug coverage even without "wrap around" benefits will receive substantial new assistance with their drug costs.

Providing Coverage for Dual Eligibles and Other State Issues

- Transition from Medicaid to Medicare for Dual Eligibles -- CMS received many comments about the transition of "full-benefit dual eligible" Medicaid-Medicare beneficiaries to Medicare drug coverage. The final rule ensures that those beneficiaries will be placed into a Medicare prescription drug plan before the end of 2005 so they will continue to get the drugs their physicians say they need. In particular:
    - During the first half of 2005, Medicare will work with states to identify all current dual eligible beneficiaries and enroll them in the Low Income Subsidy.
    - By early fall, Medicare will notify current dual eligible beneficiaries of the upcoming transition in coverage, and let them know that the specific prescription drug plan in which they will be automatically enrolled, as well as their ability to opt-out of that plan and enroll in another.
    - Medicare, the states, and Medicare's many outreach partners will assist dual eligible beneficiaries and their designated representatives in finding out about their new coverage options.
    - Dual eligible beneficiaries can also select a different prescription drug plan during the mid-November through December open enrollment period. Those who do not do so will be automatically enrolled in the previously designated prescription drug plan. Beneficiaries who wish to change plans after enrollment may do so on a monthly basis.
    - Medicare will continue to work closely with, the states, and beneficiary advocacy and counseling groups, to assure that dual eligible beneficiaries do not experience any gaps in coverage as a result of the transition to the new drug benefit.
    - States may continue to cover the drugs not covered by the Medicare prescription drug benefit and receive Federal Financial Participation under Medicaid.

- Facilitated Enrollment of Other Low-Income Beneficiaries -- CMS has interpreted the statute to allow for the facilitated enrollment of all Medicare Savings Program beneficiaries (QMB, SLMB, and QIs) and other beneficiaries determined eligible for the low-income subsidy into Medicare prescription drug plans. CMS will work with states and beneficiary advocacy groups to identify and conduct facilitated enrollment for as many low-income beneficiaries as possible during the open enrollment period that ends in May 2006. In preparation for this effort, CMS is working with SSA and grassroots organizations to enroll as many low-income beneficiaries as possible in the low income subsidy beginning in the spring of 2005 – to provide additional time to get these beneficiaries into the coverage that works the best for them.
- Savings to States -- The final regulations reflect extensive comments and discussions involving states, in order to assure a smooth transition to the new drug coverage that provides substantial savings for states. The revised estimates of state savings in the final rule are $1 billion in 2006 and about $8 billion over the first five years of the drug benefit. States that have zero or even smaller copays than the $1-$5 for the low-income portion of the Medicare prescription drug benefit can use a portion of their savings to compensate beneficiaries for these nominal copays.

States will save for a variety of reasons:

- State Medicaid programs will spend less on prescription drugs for dual eligibles because Medicare will replace drug coverage for full benefit dual eligibles. States will get savings because the law requires that the states make monthly payments to the federal government for only a portion of the drug benefit costs for full-benefit dual eligibles. These payments are based on the state's actual costs in providing prescription drug coverage, as described below.
- States offering retiree prescription drug coverage to former state government employees (and their spouses and dependents who are Medicare beneficiaries) are expected to achieve substantial savings as a result of the Medicare retiree drug subsidy and the other options offered to employers and unions for providing retirees with prescription drug coverage at lower costs.
- SPAPs: A number of states operate State Pharmaceutical Assistance Programs (SPAPs) that provide subsidized drug coverage to individuals who will be eligible for Medicare's prescription drug benefit. By "wrapping around" the new Medicare benefit, states can provide as generous coverage for their beneficiaries at a lower cost to the states. Consequently, CMS estimates that a portion of states' spending on SPAPs will be partly displaced by the Medicare drug benefit, particularly related to lower income beneficiaries. States with Pharmacy Plus programs can similarly reduce costs by wrapping around the new Medicare benefit.

The final rule clarifies that state payments for dual eligible coverage account for the fact that certain drugs now provided by states will not be covered by the drug benefit, for example benzodiazepines, and that states can continue to get Medicaid matching funds for coverage for these drugs.

- Reducing Administrative Costs and Smoothing the Transition for States -- CMS is expanding its workgroup on state issues for drug benefit implementation, and will provide a point of contact at CMS for each state on issues related to this implementation.

- CMS intends to use this workgroup to develop further guidance and educate states about implementation issues, including:
    - Straightforward determination of low-income subsidy eligibility. SSA is establishing a smooth process for making subsidy determinations using a
    - Straightforward enrollment form, and Medicare will work with states to help them educate low-income beneficiaries about its availability. However, states are also required under the statute to provide eligibility determinations themselves. CMS will work with states, at state option, to adopt the SSA determination form and to implement other tools to limit the burden of these determinations.
    - Calculation of state payment amounts. The final rule implements the statutory requirement of using the state's actual 2003 Medicaid drug costs, trended forward, to determine the state payment amounts for Medicare providing coverage for dual eligible beneficiaries. CMS will consider any appropriate adjustments in the 2003 base amount (e.g. from final resolution of rebate calculations) in determining this base payment.
    - CMS has clarified that Medicaid administrative match funding is available for state administrative costs associated with the drug benefit implementation.
- Assisting States with State Prescription Assistance Programs – CMS is establishing a workgroup to allow for close collaboration between the agency and states with SPAPs to provide for a smooth transition, building on the recently-completed work of the SPAP Commission

Improving the Medicare Advantage Program

In addition to soliciting public comments on the proposed rules strengthening the Medicare Advantage program, CMS, posted advance drafts of plan application procedures for comment on its web site. As a result, the agency received much helpful advice on ways to help make the Medicare Advantage program work better.

Changes that will maximize plan participation and enhance the opportunities for beneficiaries to obtain additional benefits and lower their out-of-pocket medical costs include:

- Essential Hospitals -- Medicare beneficiaries in rural areas will be aided as CMS enhanced procedures for identifying and supporting "essential hospitals" as network members. This will make it easier for regional PPO plans to provide coverage in rural and other areas with limited hospital availability.
- Within-Region Adjustments in Regional Plan Payments -- Medicare will implement adjustments in payments to regional plans based on the geographic location of their actual enrollees. This step helps regional PPO plans offer uniform benefits: it protects plans from unexpected losses if more beneficiaries enroll from high-cost areas, and it prevents excessive payments if more beneficiaries enroll from low-cost areas.
- Mid-year Benefit Changes -- The final rule allows Medicare Advantage plans to make mid-year benefit enhancements during part of the year.
- Local PPO Plan Participation -- Existing local Medicare Advantage plans are allowed to offer new local preferred provider (PPO) plans in existing service areas and will not be affected by the local plan moratorium, providing access to additional PPO coverage.
- Grievances and Appeals -- Medicare Advantage plans will have to establish uniform grievance and appeal procedures, as well as notice and timeliness procedures to ensure that beneficiary's rights are protected and that they are understood.

- Streamlined Implementation -- CMS have made dozens of refinements in the technical standards including an emphasis on eliminating duplicative requirements. These refinements will greatly facilitate the smooth working of key processes such as plan bidding, network development, and beneficiary enrollment.
- PACE -- The proposals to allow flexibility to PACE plans were tailored to provide even greater accommodation to the special characteristics of these plans and the special services they provide to frail elderly population.

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