MMA Q's and A's

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1. Benefits of the Medicare Modernization Act

1. Why is the MMA a good thing for Medicare beneficiaries?

The new Medicare law, known as the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), was signed by President Bush on December 8, 2003, and will, for the first time in its history, give all Medicare beneficiaries access to prescription drug coverage. The Act provides help with the cost of drugs for the lowest income beneficiaries and an immediate prescription drug discount card for all beneficiaries until the full plan is available in 2006. Additionally, the Act adds some new preventive services and more choices for how people get their services, through the traditional Medicare program, or through an HMO or PPO (preferred provider organization).

Medicare Drug Benefit
Beginning in 2006, Medicare beneficiaries will have access to the standard drug benefit described below. Although drug plan sponsors may change some of the provisions below, the benefit offered must be at least equal in value to the standard benefit. Standard coverage includes:

- A monthly premium of about $35
- A deductible of $250
- Coinsurance of 25 percent up to an initial coverage limit of $2,250
- Protection against high out-of-pocket prescription drug costs, with co-pays of $2 for generics and preferred multiple source drugs and $5 for all other drugs, or 5 percent of the price, once an enrollee's out-of-pocket spending reaches a limit of $3,600

Those beneficiaries with limited savings and low incomes will receive a more generous benefit package, as described below:

All people eligible for both Medicare and Medicaid (full dual eligibles), as well as other Medicare beneficiaries with limited savings ($6,000 for individuals and $10,000 for couples) and incomes below 135 percent of the federal poverty line ($12,123 for individuals, $16,362 for couples in 2003) will have:

- A $0 deductible
- A $0 premium
- No gap in coverage
- Co-pays of $2 for generics and preferred multiple source drugs and $5 for all other drugs, up to the out-of-pocket limit [NOTE: *For full dual eligibles under 100 percent of poverty, the co-payment is reduced to $1 and $3. Residents of nursing home do not have to pay out-of-pocket costs.]*
- $0 co-pay for all prescriptions once the out-of-pocket limit is reached.

Other Medicare beneficiaries with limited savings ($10,000 for individuals and $20,000 for couples) and incomes below 150 percent of the federal poverty level ($13,470 for individuals; $18,180 for couples in 2003) will have:

- A sliding scale monthly premium of about $35 for beneficiaries with incomes of 150 percent of the federal poverty level

- A $50 deductible
- No gap in coverage
- Coinsurance of 15 percent up to the out-of-pocket limit
- Copays of $2 or $5 once the out-of-pocket limit is reached

The Medicare-Endorsed Prescription Drug Discount Card

Medicare beneficiaries without drug coverage will be eligible for the Medicare-endorsed Prescription Drug Discount Card, which will be available in from June 2004 until the full benefit is implemented. The card program will save beneficiaries between 10 and 25 percent on most drugs. Those with incomes below 135 percent of the poverty level will be given immediate assistance through a Medicare-endorsed discount card with a credit of $600 annually to help pay for drugs.

New Preventive Benefits

Beginning in 2005, all newly enrolled Medicare beneficiaries will be covered for an initial physical examination. All beneficiaries will be covered for cardiovascular screening blood tests, and those at risk will be covered for a diabetes screen. These new benefits can be used to screen Medicare beneficiaries for many illnesses and conditions that, if caught early, can be treated, managed, and can result in far fewer serious health consequences.

Other Helpful Provisions

In addition, the new Medicare law:

- Updates physician payments by $600 million in 2004 alone;
- Increases payments to home health agencies by 5 percent for services furnished in a rural area for one year;
- Increases payments to ambulance providers and suppliers in rural areas;
- Eliminates cap on outpatient services for physical therapy, speech language pathology and occupational therapy

2. More Choices

1. Will there be any choices of programs? Why can't seniors have the same coverage as the federal employees?

Yes, there will be new choices for beneficiaries in Medicare. Interested insurers can offer preferred provider organization (PPO) plans, which will be called Medicare Advantage (MA) regional plans. PPOs have a network of doctors and hospitals that agree to take care of Medicare patients for a set amount. PPOs also allow enrollees to see doctors who are not in the network, but the patient usually has to pay more. PPOs have been a growing form of health insurance and

are now the most popular type of coverage in the private market. In 2002, PPOs accounted for 52 percent of individuals covered under employer-sponsored group insurance.

Unlike the plans in the current Medicare+Choice (M+C) program, which often only operate in a county or group of counties, the new regional Medicare Advantage PPOs will serve entire state or multi-state areas. This will bring more plan options to rural areas by grouping them with the urban areas that have traditionally attracted managed care plans under the M+C program.

3. Privatization

1. This new law privatizes Medicare. I want to be sure that traditional Medicare is available for me.

There is nothing in the new law that will result in the privatization of Medicare. Seniors will have the option of choosing fee-for-service Medicare, as it exists today, or enrolling in a Medicare Advantage plan or PPO. The entire premise of the plan is for seniors to have more choices under Medicare, not fewer. One of the choices is to continue with fee-for-service Medicare. The new drug benefit will be available to all beneficiaries – whether they choose to stay in traditional Medicare or join a Medicare Advantage plan.

Traditional Medicare will always remain an option for those who are happy with it. This new law builds on traditional Medicare to enhance coverage and incorporate the best of what has been learned in almost 40 years of running the program.

2. The bill lets private insurers define the prescription drug benefit by setting premiums, determining the coinsurance and size of the coverage gap and by defining which drugs will be covered.

The new law allows plans offering drug coverage to make some limited changes in the drug benefits they offer, so they can quickly respond to beneficiaries' preferences. By law, however, the total value of the benefit must be at least equal to the value of the standard Medicare coverage. Additionally, Medicare must approve any proposed changes to standard coverage that a plan wishes to offer. Under the new law, plans may have a formulary or list of drugs they cover, but beneficiaries must still receive all negotiated discounts on drugs, regardless of whether any particular drug appears on any formulary.

3. Subsidizing private plans called for in the new law will unravel Medicare and force seniors to join HMOs and other private insurance plans. It will create an insurance "death spiral" as healthier people leave Medicare for cheaper private plans, leaving the traditional program with the oldest, sickest, and most expensive patients.

The bill undermines the fairness of the traditional Medicare program, in which every beneficiary pays the same premium and gets the same coverage. Instead, some beneficiaries will be forced to pay more for their medical coverage and drug benefits will vary from place to place and even within the same community.

Competition between traditional Medicare and private plans will only occur on a limited basis in a few cities. The Comparative Cost Adjustment Program, as it is called, is a demonstration that would provide for limited competition between private plans and traditional fee-for-service Medicare to begin in 2010. It would last six years and run in six cities around the country. Under this demonstration, the beneficiary Part B premiums could increase if traditional fee-for-service were more expensive to run than private plans. In any case, premiums could change by no more than 5 percent per year.

4. Health Plans

1. This law is a give-away to HMOs. It pays private plans an average of 109 percent of the traditional Medicare rate, creates a $12 billion dollar slush fund for HMOs, and allows these plans to continue to lure only the healthiest beneficiaries into their plans and out of the traditional Medicare program.

Medicare must approve all language that plans use to recruit beneficiaries, and all plans must enroll all qualified beneficiaries who wish to enroll. [Qualified beneficiaries are those enrolled in Parts A and B.] To the extent that any plan is paid above what it takes to provide the basic Medicare benefit, the amount is channeled back into additional benefits, such as vision and dental benefits, and beneficiary savings, such as reduced premiums or co-payments.

2. Traditional Medicare is much more efficient and much more affordable than private health insurance. Government administrative costs are 3 percent while those incurred by private insurers typically run between 15 percent and 20 percent.

By law, Medicare spends only the amount that is appropriated to it in the congressional appropriations process. The Medicare program does not have the option of spending any additional money, even if that expenditure would ultimately make the program more efficient. Medicare is more affordable than private insurance because the federal government subsidizes Medicare through taxes.

Under this new law, beneficiaries can choose to stay in traditional Medicare or shop around to find a private plan that better meets their needs. These Medicare Advantage plans will be competing for Medicare beneficiaries based on price and quality of services they provide. The more efficient Medicare Advantage plans will be more attractive to beneficiaries since they will benefit most from the savings. This will help keep plans more affordable for the beneficiary.

3. I don't want to get my drug benefit from a health plan.

It will not be necessary to join a health plan to enroll in the new Medicare drug benefit. Beginning in 2006, *all* Medicare beneficiaries will have access to the standard benefit, with extra help available to those with low incomes. (see Section 1, question 1 "Medicare Drug Benefit" for a description of drug plan and subsidies.)

4. Why are you paying all this money to health plans but not my doctor?

Your doctor will be getting a raise under the new Medicare law. Under the MMA, physicians will be getting a 1.5 percent increase in their payments. If the law hadn't passed, Medicare's payments to doctors would have gone down by 4.5 percent. This could have resulted in fewer doctors seeing Medicare patients.

Medicare Advantage plans will also see increased payments in 2004. The increases will average 10.6 percent across plans. Under the MMA, these increased payments must be used by plans to:

- Reduce beneficiary premiums or co-pays
- Enhance benefits
- Stabilize or expand the network of doctors and other health care providers
- Reserve funds to offset premium increases or reduced benefits in the future

So, you can see that increases to health plans are aimed at helping Medicare beneficiaries.

5. Prescription Drug Coverage

1. I keep hearing about a "doughnut hole." What is it and why can't I get more complete drug coverage?

It is true that the benefit requires beneficiaries with incomes above 150 percent of poverty to pay all of their drug expenses between $2,250 and $5,100. However, beneficiaries spending in this range will still have access to discounts obtained by the plan sponsor. However, this benefit has been designed in a way that protects the most vulnerable Medicare beneficiaries. All beneficiaries who are entitled to both Medicare and Medicaid, as well as other low-income beneficiaries with limited savings, face no initial coverage limit. Also, beneficiaries with high drug costs will have only minimal co-payments once the out-of-pocket limit is reached.

Medicare statistics show that in 2000 beneficiaries without drug coverage had total average drug spending of $732 (all of it out-of-pocket), far below the $2,250 "doughnut hole," while beneficiaries with coverage had total average spending of $1,337 ($395 out-of-pocket). This legislation will help, in particular, older beneficiaries, including those over 85, who are more likely to have no drug coverage than younger beneficiaries.

2. Why do we have to wait until 2006 for assistance with drug costs?

Help with paying drug costs will be available immediately in the form of the Medicare Prescription Discount Drug card. The drug card, available in June 2004, will offer immediate relief in the form of 10-25 percent discounts off retail prices of most drugs. The card, while not a drug benefit, will be available until the full benefit takes effect in 2006. (see Section 1, question 1 for full description of benefits).

6. Prescription Drug Coverage: Negotiation

1. This bill is only helping the drug companies and not the seniors! Why can't Medicare negotiate prices with the drug companies?

This is certainly not true. Seniors and the disabled will get help immediately through the Medicare drug discount card (see Section 1, question 1 for description) The card will provide significant savings from current retail prices for most drugs. And, those with low incomes will be eligible for special assistance.

Drug prices will be subject to marketplace competition, which is exactly what happens under the federal employee health benefit plan (FEHBP). The FEHBP leaves price negotiations up to the private plans that provide coverage for federal retirees. It has worked well for these plans, and we believe it will work for Medicare.

Private plans (including those providing a benefit to traditional Medicare beneficiaries) will negotiate directly with manufacturers and others to get the lowest possible prices for drugs. Plans that don't negotiate the best prices will not be able to offer the best premiums and will lose customers to plans that are a better deal.

Organizations such as Pharmacy Benefit Managers (PBMs) and insurers have significant experience negotiating prices. Over 200 million Americans have their drug benefits managed by a PBM, including many seniors (primarily those with employer-sponsored insurance coverage).

2. This bill does nothing to contain runaway drug prices.

On the contrary, this bill will allow competition to hold down prices. Medicare beneficiaries will obtain their prescription medicines through powerful purchasers, PBMs, who will negotiate with pharmacies and prescription drug manufacturers to get the best deal. The non-partisan Congressional Budget Office projected that Medicare would get better prices through a drug plan based on consumer choice than one that uses government price controls. In addition, this bill implements new provisions that will speed the entry of generics to the market, making drugs more accessible and affordable. It also should be noted that Medicare does not purchase drugs or other items, but instead reimburses purchasers.

3. Why can't we have price controls?

Medicare beneficiaries account for about 40 percent of the dollars spent on prescription drugs in the U.S. If Medicare adopted price controls, the potential implications for the market would be large. While some government programs (including those managed by the Veterans Administration and the Public Health Service) have had some success with mandated pricing, these programs are much smaller than Medicare, and their pricing strategies do not have as great an impact on the health care market. VA and DoD payments for prescription drugs account for less than 1 percent of spending for

prescription drugs in the United States (2001). Price setting by a program as large as Medicare may not permit adequate investment in research and development that we need for the future.

7. Prescription Drug Coverage: Drugs from Canada

1. Why can't we buy drugs from Canada?

> Medicine you buy from outside the United States may be fake, contain the wrong active ingredient, wrong amount or no medicine at all. The medicine may not be appropriate to treat you and your condition — and it could be dangerous to your health. If you buy foreign medicine from an Internet site, from a storefront business that offers to order medicine for you, or during visits outside of the United States, you are risking your health. Even medicine that appears to be the same or have the same brand name as the medicine you buy in the United States can be dangerously different.
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> The current law that bars the importation of pharmaceuticals into the U.S. was a result of a multi-year congressional investigation into the influx of counterfeit drugs entering the U.S. In this bill, Congress decided to uphold the law unless the Secretary of Health and Human Services determines that importation can be done safely, and can actually save consumers money. Both Secretary Thompson and his predecessor, Donna Shalala, have determined that allowing reimported drugs would increase the likelihood that homes, shelves and pharmacies in towns and communities across the nation would include counterfeit drugs, cheap foreign copies of FDA-approved drugs, expired drugs, contaminated drugs, and drugs stored under inappropriate and unsafe conditions.

Counterfeit drugs--phony replicas of pharmaceuticals--can surface anywhere. Historically, they have been more common in foreign countries than in the United States. And while the Internet has given customers the convenience of buying drugs from the privacy of their own homes. It also has created a serious oversight problem making it much more difficult to determine where orders are coming from. A recent series of spot examinations of mail shipments of foreign drugs to U.S. consumers conducted by the Food and Drug Administration, U.S. Customers Service and the U.S. Border Patrol revealed that these shipments often contain dangerous or unapproved drugs that create potentially serious safety problems.

8. Who the MMA Helps

1. How does this help the middle class?

This new law commits more than $400 billion over the next 10 years by the President and the Congress to ensure that no senior or disabled person has to choose between groceries and prescription drugs. As a result of its passage, every Medicare beneficiary in America will have the opportunity to enroll in a Medicare plan that provides prescription drug coverage. The plan is designed to provide the most help for those with the greatest need, such as Medicare beneficiaries with the lowest incomes and the highest levels of spending on drugs.

2. What are the poverty levels in numbers?

In 2004 the numbers are as follows.
For individuals:
100 percent - $9,310 (about $775 a month)
135 percent - $12,568 (about $1,047 a month)
150 percent - $13,965 (about $1,163 a month)

For couples:
100 percent - $12,490 (about $1,040 a month)
135 percent - $16,861 (about $1,405 a month)
150 percent - $18,735 (about $1,561 a month)

These federal poverty income numbers are adjusted each year and will be higher when the drug benefit goes into effect in 2006.

3. How does the new Medicare law help those with low incomes?

This bill provides the most help for those with the greatest needs. Beneficiaries with limited savings and low incomes will finally be able to more easily afford prescription medications.

Medicare beneficiaries with limited savings and incomes below 135 percent of poverty will have a $0 deductible; a $0 premium; no gap in coverage; co-pays of $2 for generics and $5 for name brand drugs up to the out-of-pocket limit; and $0 co-pay for all prescriptions once the out-of-pocket limit is reached. Beneficiaries who are eligible for both Medicare and Medicaid will also have $0 deductible; $0 premium; co-pays of no more than $2 for generics and $5 for brand name drugs up to the out-of-pocket limit; and $0 co-pay for all prescriptions once the out-of-pocket limit is reached. Dual eligibles under 100 percent of poverty have co-pays of $1 and $3, and those in medical institutions and nursing facilities have no co-pays.

4. The bill imposes a harsh and demeaning "assets test" on beneficiaries who are poor. Many of them will find that they don't qualify for special assistance despite their low incomes.

Like all needs-based programs, the assets test ensures that those seniors who are most in need receive the aid. Income is not the only determining factor when identifying ability to pay, and we believe that it would be unfair to grant the same benefits to two seniors with identical incomes if one had substantial savings and one had minimal assets.

The new Medicare drug card program was included in the Medicare Prescription Drug, Improvement, and Mobilization Act of 2003 (MMA) as a means to provide seniors, many with only limited assets, immediate assistance on prescription drug costs before the comprehensive Medicare drug benefit starts in 2006.

5. Is the prescription drug cost based on household or individual costs?

Medicare coverage is based on an individual's drug costs.

9. Prescription Drug Card

1. What is the cost of the prescription drug card? Is it good for both years or do you have to renew it?

Medicare enrollees may be charged an annual enrollment fee of up to $30. However, the cost of the card is free for individuals with incomes below $1,047 a month or married couples with incomes below $1,405 a month. The card is good for both years and it doesn't have to be renewed.

2. When can we get our prescription drug card? Who gets the $600 credit?

All Medicare beneficiaries may get a Medicare-endorsed Prescription Drug card beginning in June, other than Medicare beneficiaries who have drug coverage under Medicaid. Individuals with monthly incomes below about $1,000 a month will be able to get $600 in assistance added to their drug card. Couples with monthly incomes below about $1,400 a month will be able to get $600 per year in assistance added to their drug cards.

[In 2004, 135 percent of the federal poverty level is $1,047 a month for individuals and $1,405 per couples. There is no asset test for this transitional assistance. Medicaid recipients already receiving a drug benefit are not eligible for transitional assistance, nor are individuals with drug coverage under Tricare, FEHB, or employer-sponsored insurance.]

3. Can I have more than one prescription drug card at the same time? If I don't like my drug card, can I drop it and get another one?

Individuals can only enroll in one Medicare-endorsed card at a time. Drug cards will initially be available in June 2004. Individuals may switch to a different drug card for 2005. Individuals will have a choice of at least two different drug cards. Card sponsors may charge no more than a $30 annual enrollment fee.

10. Prescription Drug Advertising

1. Can we put a ban on advertising for the Rx companies?

No. The Supreme Court has ruled that the First Amendment protects commercial speech, including advertisements by prescription drug manufacturers, provided that it is truthful and not misleading. Advertising, for example, helps to alert beneficiaries and other patients to symptoms they might have dismissed without seeking treatment.

11. Employer Retirement Health Plans

1. My company's policy has a clause that if the government or any other private entity provides any other benefits for me, then they will drop me. Frankly, I don't want that to happen because I have a great plan right now. What do you have to say about that?

The new law strengthens the safety net for seniors by providing financial incentives for employers to continue offering prescription drug coverage for their retirees. Today, employers and unions can drop retiree health coverage at any time and some are doing so, highlighting the need for reform. In 1988, for example, 66 percent of large employers offered their retirees drug coverage. In 2003, only 33 percent of large employers offered their retirees drug coverage

For the first time, Medicare will provide payments and incentives to employers and unions so they won't drop coverage for retirees - a substantial improvement to the health care delivery system for seniors.

Retirees whose employers continue to offer prescription drug coverage have the option to decline the new Medicare drug benefit and remain in their employer plan.

To qualify for the employer-sponsored coverage subsidy, the employer or union would show that its coverage is at least as generous as the new Medicare drug benefit in Part D. About one-third of Medicare beneficiaries currently have drug coverage through their former employer, and the coverage is typically among the most generous type available.

The new federal subsidy will pay 28 percent of beneficiaries' drug costs between $250 and $5,000. Employers will be able to receive federal subsidy payments on average of $611 and as high as $1,330 per beneficiary.

Beneficiaries who continue with their employer-sponsored drug coverage will be able to enroll in Medicare Part D at a later date (without any penalty), should their employer ever drop such coverage.

2. CBO says that this bill will cause 2.7 million retirees to lose their employer-sponsored health coverage.

As noted above, for the past several years, employers have been dropping retiree health coverage at an alarming rate. In 1988, for example, 66 percent of large employers offered their retirees drug coverage. In 2003, only 33 percent of large employers offered their retiree drug coverage. The new law attempts to slow this disturbing trend by paying employers 28 percent of each enrollee's annual drug costs between $250 and $5,000.

12. Veterans Benefits

1. Will this effect VA benefits?

No. Nothing in the new law changes how veterans receive their VA benefits.

13. Geographic Variation

1. Is it true that Medicare pays different charges for the same things in different states?

Yes. Medicare starts with a base amount, and then adjusts payments depending on where in the country the doctor is practicing. The adjustments are made based on surveys of costs in 93 geographic areas. For example, Medicare pays doctors based on three things: work, practice expenses or overhead, and malpractice. In some areas, practice expenses – such as rent, are higher than others. In New York City, a doctor may pay $10,000 a month in rent – but a doctor in Dayton, Ohio would pay $3,000 for the same space. Medicare takes these differences into account.

2. This bill doesn't guarantee coverage to seniors in rural areas.

In Section 101 of the new law it says that Medicare "shall ensure that each Part D eligible individual has available...a choice of enrollment in at least two qualifying plans." Additionally, Medicare is permitted to do what it takes to make sure everyone has a choice of two plans.

14. Medigap

1. I want to keep my Medigap coverage. Will this law let me?

Yes. Medicare beneficiaries covered under a Medicare Supplemental policy (also known as a Medigap policy) may keep their Medigap policy. In 2006, individuals who do not hold a Medigap policy may only purchase one that does not include prescription drug coverage. This is because the new Medicare drug coverage is a better deal – no matter how much you spend a month in drugs.

[**H & I Medigap plans**: Premium ranges between $120-240 a month ($1,440 to $2,880 annually). Coverage: after meeting a $250 deductible, cover 50 percent of costs between $250 and $2,750 ($1,250 annual). There is no catastrophic coverage (and no government subsidy].
The J plan: Premium ranges between $150-250 a month ($1,800 to $3,000 annual). Coverage: after meeting a $250 deductible, cover 50 percent of costs between $250 and $6,250 ($3,000 annual). There is no catastrophic coverage (and no government subsidy).]

Medigap policies, which supplement Medicare in other areas, will still remain available in 2006 and beyond. However, this year 7.3 million people with Medicare are expected to enroll in the prescription drug discount card program and save between $1.4 billion and $1.8 billion in discounts on their prescriptions. Of the 7.3 million beneficiaries, an estimated 4.7 million will qualify for the $600 credit to purchase prescription drugs in 2004 and save an estimated $2.4 billion, in addition to the savings from the discounts. This program is not intended to be a prescription drug benefit, but rather a measure to help people until the drug benefit is implemented on January 1, 2006.

15. Cost Containment

1. This benefit is too expensive. CBO thinks it will cost $400 billion, but it will in reality cost far more than that. In fact, CMS's own actuaries believe it will cost over $500 billion.

The bill provides for a new prescription drug benefit in a very cost efficient manner. Drug plans will be able to employ the best-cost containment strategies available in the private market today. CBO estimates this cost management to save 20 percent in 2006, growing to 25 percent by 2013.

2. The cost containment mechanisms in this bill end the Medicare entitlement for seniors.

Quite the opposite is true. The cost containment mechanisms in the bill ensure Medicare's financial viability for current and future beneficiaries. (See below for more details)

3. The cost containment mechanisms in the bill are completely ineffectual. The costs of this program will explode in the future.

- The bill includes cost containment provisions to ensure that taxpayers don't fund any more than 45 percent of Medicare's costs. Premiums paid by beneficiaries pay the rest. If the Medicare Trustees project that taxpayer funding will exceed 45 percent of costs, the President must submit a legislative proposal to bring those costs back down.

16. HSAs

1. Health Savings Accounts (HSAs) are for the healthy and wealthy and will destroy employer-sponsored health coverage.

HSAs are tax-advantaged savings accounts that can be used to pay for medical expenses incurred by individuals, their spouse or their dependents. HSAs are open to everyone who has a health insurance plan with a deductible of at least $1,000 for one person or $2,000 for a family.

HSAs are portable, so an individual is not dependent on a particular employer to enjoy the advantages of having an HSA. If the individual changes jobs, they can keep their HAS. In addition, individuals over age 55 can make extra contributions to their accounts and still enjoy the same tax advantages. In 2004, an additional $500 can be added to the HSA. By 2009, an additional $1,000 can be added to the HSAs. HSAs will encourage more employers to offer health insurance to their employees since high deductible plans cost less to offer.

2. This bill contains tax breaks for the healthy and wealthy that have nothing to do with providing drug coverage to the elderly.

The HSA provision will help many more individuals to afford insurance coverage. Moreover, HSAs will encourage more efficient use of medical services, as consumers will have an incentive to use their health care savings accounts wisely.

17. Education and Outreach

1. How will you let Medicare beneficiaries know about the new law?

The Department of Health and Human Services, together with the Centers for Medicare & Medicaid Services will launch an exhaustive beneficiary education campaign, called *Medicare & You*. It will consist of print materials, including the 2004 *Medicare & You Handbook,* which will be mailed to 39 million Medicare enrollees. The handbooks are offered in English and Spanish. They are also offered in large print and Braille.

In addition to the handbook and other print materials, the campaign will feature community-based outreach, a national advertising campaign, the Internet site, www.medicare.gov and a toll-free number anyone can call at 1–800-MEDICARE. The toll-free number has customer service representatives 24 hours a day, seven days a week.

18.Oncology Issues

1. Is it true that my cancer doctor will not treat me under Medicare in 2006? Why don't you just give them more money?

MMA requires the Secretary of HHS to decrease the Medicare payment for drugs and increase payment for administering them in 2004. In a final regulation published on January 7, 2004, CMS provided the new payment rates for drugs and their administration.

Under the final rule, total physician fee schedule payments made to oncologists are estimated to increase by 47 percent in 2004**.** Payment for the highest volume drug administration services will increase anywhere from 9 percent to more and 450 percent. Drug payments are expected to decline by approximately 12 percent.

The effect of the drug payment reductions and drug administration increases are estimated to result in no change in oncology revenues in 2004.

Until this year, Medicare's payments for drugs were based on 95 percent of the average wholesale price (AWP). GAO, OIG and others criticized this payment system for overpaying on drugs. Oncologists generally accepted that Medicare overpaid for drugs using 95 percent of AWP. However, they argue that the overpayments were necessary to subsidize the underpayment for administration of the drugs.