MEDICARE PRESCRIPTION DRUG,

IMPROVEMENT

And

MODERNIZATION ACT of 2003

By

William C. Hambley, Esq.

Pro Seniors, Inc.
7162 Reading Rd., Suite 1150
Cincinnati, Ohio 45237

(513) 345-4160

www.proseniors.org

Copyright © 2007 Pro Seniors, Inc.

MEDICARE PRESCRIPTION DRUG, IMPROVEMENT and MODERNIZATION ACT OF 2003

Table of Contents

I. Medicare Prescription Drug Benefit Program 2

II. Employer Provided Retiree Prescription Drug Benefits 6

III. Medicaid/Medicare Enrollees Must Use The Medicare Prescription Drug Program 7

IV. Premium and Cost Sharing Subsidies for Low Income Individuals 8

V. Drug Formulary Exceptions And Appeals And Duty To Provide One Time Transition Refill Prescription To Individuals With Non-Formulary Prescriptions 10

VI. Medicare Supplemental Insurance 12

VII. Medicare Advantage 13

VIII. Changes To Medicare Part B 14

IX. Cost Containment Provisions 17

I. Medicare Prescription Drug Benefit Program.

A. Enrollment.

(Act §101(a) adding §1860D-2 and §1860D-4 of the Social Security Act.)

1. The prescription drug benefit is delivered by private companies. Each company has a one year contract with Medicare.

2. Each of these companies offers two to four different drug plans. Each plan offers additional options to the one plan that is equivalent to the "standard Medicare drug plan." The options are primarily which drugs are on a particular plan's formulary and how much additional out-of-pocket costs the beneficiary will pay if she chooses the "non-standard" plan option.

3. Medicare is prohibited from negotiating drug prices for the 43 million Medicare beneficiaries. Rather. each private, for profit, company will negotiate the price of their drugs on behalf of their members, a much smaller number of Medicare beneficiaries. Medicare is also prohibited from even suggesting to the private companies what a reasonable price would be for a particular drug. (§1860D-11(h)(i) of the Social Security Act)

4. A beneficiary must have either Part A and/or Part B Medicare to enroll in Part D.

5. A beneficiary can enroll through the Medicare 800 telephone system or at Medicare's web site, www.Medicare.gov. However there have been some substantial discrepancies between the Medicare information and the drug plan's actual benefits, costs and even the covered medications on its formulary. It is therefore best to confirm the Medicare information about the plan through direct contact with the drug plan and then enroll directly with the private company.

6. Each area must have at least one stand-alone drug company offering the Medicare Standard drug plan or its equivalent for persons choosing to remain in traditional Medicare.

7. Medicare Advantage Plans (MAPs, the Medicare managed care option) must offer at least one integrated managed care plan with a drug benefit that is actuarially equivalent to the standard Part D plan. To enroll in a Medicare Advantage Plan, a beneficiary must leave the traditional Medicare program and receive all of her health care and drugs from the managed care company.

B. Coverage Provided.

1. Part D plans may use formularies and pay only for drugs listed on its formulary as long as the plan covers at least two medications for each Medicare designated therapeutic or illness group.

2. Plans may also change the specific drugs on their formularies with sixty days advance notice to their members, physicians and Medicare.

3. A beneficiary purchasing a non-formulary medication, who does not successfully appeal the formulary's application to her, will receive no Medicare Part D coverage for that medicine and the drug's out of pocket cost will not be counted towards the Part D deductible and co-payment limits.

4. Beneficiaries have a right to appeal a non-formulary, and therefore non-covered, medication. But they must obtain a doctor's certification that the medicine being prescribed is better for their medical condition than the two offered on the formulary or that the ones offered on the formulary will be medically adverse for the patient.

5. Most Part D plans use a tiered formulary, where more expensive drugs have a higher co-pay. The only way a beneficiary can avoid the extra cost is if she can successfully appeal and prove that the drug is superior to the lower cost ones on the plan's formulary for the same medical condition.

6. Plans must also offer actuarially equivalent benefits to the standard plan. Plans have a great deal of freedom as to how to structure their equivalent benefits.

    a. Beneficiaries trying to compare several actuarially equivalent plans have a very difficult time evaluating the plans. This is especially true since the plans have a great deal of freedom and discretion in selecting the drugs that will be covered by their formularies.

    b. The only practical way to compare Part D plans is through the plan comparison program at www.medicare.gov, which compares each plan on an annual out-of-pocket cost basis.

C. Standard Benefit.

(Act §101(a) adding §1860D-2 and §1860D-4 of the Social Security Act)

1. The specific amount of the Part D plan's monthly premium is not set forth in the statute.

    a. Each year the Medicare standard monthly Part D premium will increase by the rate of increase in the overall "standard premium bid amount increase."

    b. $27.35 is the beneficiary's 25.5 % share of the national average standardized bid amount for monthly Part D premiums in 2007. This is also the maximum that the Part D low-income subsidy program, called Extra Help, will pay for a Part D plan's monthly premium.

    c. The actual monthly premium charged by a plan will vary a great deal depending on the medication formulary being offered and the marketing strategy of the individual drug plan.

2. There is a $265 annual deductible.

    a. Only expenditures for "plan approved" or "covered" medications, i.e. medications on the plan's formulary, count toward the annual deductible.

3. The plan will pay 75% ($1,601.50) of the drug cost between $266 and $2,400 (the next $2,135 of drug costs), of plan approved or covered medications. The beneficiary has a 25% co-payment for the covered medication ($533.50).

4. For the drug cost between $2,401 and $5,451.25 (the next $3,051.25 of drug costs), the beneficiary is responsible for 100% of the cost of the covered medication expenses.

5. Once a senior has reached $5,451.25 in total annual covered drug costs, and incurred $3,850 in out-of-pocket costs for covered medications, the plan will pay 95% of the cost of any additional covered drugs in that year.

6. The $3,850 in out-of-pocket costs does not include the cost of the Part D monthly premium the beneficiary has to pay to maintain her Part D plan enrollment.

7. Of the first $5,451.25 in covered medication expenses (not counting the monthly Part D drug premium), Medicare will pay a maximum of $1,601.50.

D. Other Considerations.

(Act §101(a) adding §1860D-1 and D-2 and §1860D-4 and §1860D-11 of the Social Security Act)

1. During Part D's initial enrollment period, a beneficiary was able to change her Part D plan enrollment once during the first five and a half months of 2006.

2. But after that point, beneficiaries may disenroll from their Part D drug plan and enroll in a new drug plan only during the six week open enrollment period from November 15 through December 31 each year. Such a plan change will be effective January 1st. After this period they will only be permitted to change from one stand alone drug plan to another stand alone drug plan under very limited circumstances until the next November 15th open enrollment period begins.

3. For the 12% of Medicare beneficiaries in a Medicare Advantage Plan who want to go to another Medicare Advantage plan or back to traditional Medicare with a stand alone drug plan or from traditional Medicare to a Medicare Advantage plan, there is an additional MAP enrollment period from January 1, 2007 through March 31, 2007.

4. Drug plans will be able to change their formularies and the costs under them throughout the course of a year, as long as they continue to offer two medications for each of approximately 190 Medicare designated therapeutic groups.

5. A substantial new illness or medical condition might require expensive medications not on a plan's formulary; or if on the formulary, it may be on the tiered more expensive medications list requiring much greater out-of-pocket costs not covered by the standard benefit.

6. For a beneficiary with a $5,451.25 out-of-pocket drug bill, Medicare would pay a maximum of $1601.50 for covered medications only. The beneficiary would pay $3850 in deductibles and co-payments and would also pay an additional monthly premium for this coverage.

E. Voluntary.

(Act §101(a) adding §1860D-1, D-11, D-13, D-14, and D-16 of the Social Security Act)

1. There is a 1% per month, lifetime premium penalty for each month of delay in enrolling in the Part D program after the initial enrollment period ended on May 15, 2006.

   a. For a delay of 7 months; there will be a 7% per month additional lifetime penalty (24 month delay, at least a 24% penalty) added on to each monthly Part D premium. The amount of the monthly penalty will be computed by multiplying the per cent of penalty times the national standard monthly premium that will be calculated each year. The cost of this penalty in dollars will increase as the monthly standard premium increases from year to year.

   b. In addition, the next open enrollment period will not be until November 15th through December 31st of each year. So there is a limited time period within which a beneficiary is permitted to enroll in Part D and thus avoid further late enrollment penalties.

2. On January 9, 2007, CMS Acting Administrator Leslie V. Norwalk announced the elimination of the 2007 late enrollment penalty for any beneficiary eligible for the low income subsidy for a Part D plan even if they failed to sign up by the program's initial deadline. Thus, once they qualify for SSA's Extra Help Program, low-income Medicare beneficiaries can enroll in a Medicare prescription drug plan with no penalty through December 31, 2007.

3. If a person is a dual eligible, i.e. she has both Medicaid and Medicare, Medicaid will no longer pay for prescription medications. A Medicaid-Medicare enrollee must get her prescription medications through the new Medicare Part D Drug program. Approximately 6.2 million seniors are dual eligibles.

4. If a person is in a retiree health plan or other insurance plan with prescription drug coverage that is certified as offering a drug benefit equivalent to the Part D standard plan, the retiree and their covered dependent will not be subject to the late enrollment penalty if they enroll in the Part D program within 63 days of any loss of this coverage not due to a failure to pay premiums on the coverage.

II. Employer Provided Retiree Prescription Drug Benefits.

(Act 101(a) adding §1860 D – 22 of the Social Security Act)

A. Retiree health plans offering actuarially equivalent coverage to the Medicare Part D benefit will receive from Medicare a 28 percent payment for drug costs between $265 and $5,451.25.

1. The plan sponsor annually must attest that the actuarial value of the plan is at least equivalent to the standard prescription drug coverage under Part D of the Act.

2. A notice that the retiree prescription drug coverage is equivalent to the Part D drug benefit should be mailed to each retiree between September 15th and November 15th of each year.

B. A retiree enrolled in a retiree health plan that offers an actuarially equivalent drug benefit to the Part D plan may choose not to enroll in the Part D plan.

1. The retiree will not have to pay the one per cent per month, lifetime penalty that others, who delay enrollment in the Part D program, will have to pay.

2. The retiree must join the Medicare Part D program within 63 days of the end of his retiree prescription drug coverage, which ended for reasons other than the non-payment of retiree health premiums or upon receipt of a written notice that the retiree plan's drug benefits are no longer actuarially equivalent to the Part D benefit.

C. The amount of each retiree's Medicare subsidy will be determined by the total prescription drug costs paid under the plan, whether it is the retiree who pays that cost out-of-pocket or the cost is paid by the plan.

1. If a retiree plan provides a greater drug benefit than the Part D benefit, the retiree plan could decide to shift a higher proportion of the cost of the plan onto the retiree and still receive its full subsidy.

   a. Of the first $5451.25 in prescription drug costs under the new Medicare Part D program, a senior will pay $3850 in co-payments and deductibles for covered medications and Medicare will pay a maximum of $1601.50.

   b. The Part D benefit provides no coverage for the out-of-pocket cost of drugs between $2,400 and $5,451.25.

   c. If a retiree plan now pays 80% of prescription medication costs with a 20% co- payment benefit, the retiree plan could reduce its contribution to 40% or 50 % and increase the retiree's share to a 50% or 60% co-payment and the retiree plan sponsor would still receive its full Medicare subsidy.

d. On the other hand, the retiree plan's payments for the retiree's prescription drugs are not counted towards the retiree's out-of-pocket drug cost maximum to qualify for the Part D catastrophic coverage benefit.

e. The estimated cost of this retiree health plan subsidy is $90 billion dollars over ten years.

f. In addition to this $90 billion subsidy, the Act also provides an additional $18 billion dollars in tax incentives for employers to continue to provide some type of a retiree health plan.

   i. The Medicare expenditures for these retiree health and drug provisions are projected to be about one sixth of the total ten year, cost of this legislation.

   ii. Even with this unprecedented subsidizing of private retiree health plans, the Medicare agency estimates that employers will reduce or eliminate prescription drug benefits for about 3.8 million retirees in the first two years of the program. This number represents about 30 per cent of the 11.5 million retirees, who currently have some employer retiree prescription drug coverage.

III. Medicaid/Medicare Enrollees Must Use The Medicare Prescription Drug Program.

(Act §103 amending §1902, §1935, §1936, §1108, and §1144 of the Social Security Act)

A. As of Jan. 1, 2006, Medicaid programs no longer receive federal matching funds for the purchase of prescription medications for individuals, who are eligible for both Medicare and Medicaid.

1. The Secretary of HHS was required to develop a plan to automatically enroll into the new Medicare Prescription Drug program all individuals on Medicaid, who also have Medicare coverage.

   a. Approximately 6.2 million seniors were affected.

   b. The Secretary's assignment of plans to Medicaid beneficiaries is a blind rotation assignment and therefore many Medicaid recipients are assigned to drug plans that do not have their medications on the plan's formulary.

B. Before 2006, state Medicaid programs provided coverage for all FDA approved drugs of every drug manufacturer that had agreed to pay rebates to the states.

1. The for-profit companies that provide the Medicare prescription benefit are permitted to offer as few as two drugs for each of approximately 190 therapeutic groups.

2. If a Medicaid recipient's medicine is not offered by the for-profit company, the Medicaid beneficiary will have to pay for it without any help from the Medicare or Medicaid programs

unless the beneficiary can get her doctor to help them successfully appeal the company's drug formulary's application to her.

C. Most Medicaid recipients with incomes at 100% of the federal poverty level or less must pay a co-payment per prescription of $1/ generic and $3.10 / non-preferred brand name drug. These co-payments will also increase each year by the cost of inflation.

1. Nursing home residents on Medicaid do not have to pay these co-payments, but have to switch from the Medicaid to the Medicare Prescription Drug program.

2. Nursing home residents have to review and choose one of the companies that provide the Prescription Drug benefit and are subject to all of the choice and access limitations that are part of the new program's design.

IV. Premium and Cost Sharing Subsidies for Low Income Individuals

(1860D-14 of the Social Security Act)

A. The prescription drug benefit program provides premium and cost sharing subsidies for certain low-income eligible individuals.

1. People eligible for Medicaid and Medicare pay no premium or deductible and do not have the $3,850 doughnut hole gap in their coverage. They pay $1 per prescription for generics and $3.10 for non-preferred brand named drugs. These co-payment amounts are subject to annual inflation increases. This group is automatically enrolled in a Part D plan and determined eligible for this subsidy as of their qualifying for enrollment in both programs.

   a. Those automatically enrolled in a drug plan may not be assigned a plan that covers their medicines. They have the right to pick a different plan at any time.

   b. Medicare beneficiaries who are also on the State Medicare Buy In programs (such as QMB and SLMB), the SSI program or who have monthly income at or below 100% of the federal poverty level, $851 ($1,141, married couples), a month or less are eligible for the full low income subsidy and also have no monthly premium, deductible or co-payment gap in their coverage. They do have to pay $1 for each covered generic drug and $3.10 for each covered brand name drug. They are automatically enrolled in a Part D plan as of qualifying for these programs and Medicare.

2. Medicare beneficiaries with monthly incomes at or below $1,149 ($1,541 married couples) and countable liquid assets of $6,120 or less ($9,190 married couples) pay no premium or deductible and have no gap in their coverage. They pay $2.15 for each generic and $5.35 for each non-preferred brand name covered prescription.

3. Medicare beneficiaries with monthly incomes at or below $1,149 ($1,541 married couples) and who have liquid assets of $10,210 or less ($20,410 married couples) but above $6,120

single, ($9,190 married couples), do not have a monthly drug premium but do have a $53 deductible and no coverage gap. They also pay a 15% co-payment on covered medicines.

4. Medicare beneficiaries with monthly incomes between $1,149 and $1,192 ($1,541-$1,598 married couples) and have liquid assets of $10,210 or less ($20,410 married couples) have a $53 deductible and no $3850 coverage gap. They also have a 15% co-payment on covered medicines and a sliding scale monthly premium (from $0 - $27.35) depending on income.

   a. The maximum monthly income to qualify for a partial drug subsidy benefit is $1,277 for an individual and $1,712 for a couple. This income limit is increased each year in January or February when the federal poverty level increases.

   b. The maximum annual income for a single person to qualify for a partial drug subsidy benefit is $15,315. The maximum annual income limit will increase for each additional person supported by that income. For example, for a couple or a grandparent and child it is $20,535.

   c. Note that a low-income subsidy applicant's resources can include an additional $1,500 exclusion for burial expenses if the appropriate box is checked on Question 6 of the Low Income Subsidy Application. Thus the gross resource eligibility figures cited above can be increased by $1,500 for those applicants claiming the burial expense exclusion.

B. Countable income for the prescription drug low income subsidy is anything you and your spouse, who lives with you, receive in cash or in-kind that you can use to meet your needs for food and shelter.

1. It can be social security benefits, pension payments, or rent you charge another or interest income from a bank account.

2. It can also be income from part-time work, although some of this income will not be counted if you are disabled and have non-reimbursed work related expenses.

3. It can also be the amount of money someone regularly gives you (or pays for you) so you can pay for food or shelter costs such as rent, utility bills and groceries.

C. Countable liquid assets for the low income subsidy are assets that can be converted to cash or in a form of cash savings such as bank accounts, certificates of deposit, stocks, bonds and other investments.

1. Some assets are not counted at all, such as the homestead, furniture or furnishings, one automobile and a wedding ring and other jewelry.

   a. If an applicant promises to use up to $1,500 in savings for a funeral, it will not be counted even though it is in a bank account. If a husband and wife both make that

promise, $3,000 will not be counted as part of the couple's liquid assets.

2. Only the assets of a married couple living together will be counted.

   a. This means that if an applicant lives with an adult child, a friend, or some other adult, Social Security will only look to the value of the applicant's assets, not assets belonging to others with whom the applicant lives.

D. Applications for the Medicare Prescription Drug Low Income Subsidy are made to the Social Security Administration or local Social Security offices. The Social Security Administration is responsible for distributing and processing applications for the Low Income Subsidy.

1. Denials of financial eligibility can be appealed through a multi-tiered appeal process.

V. Drug Formulary Exceptions And Appeals And Duty To Provide One Time Transition Refill Prescription To Individuals With Non-Formulary Prescriptions.

A. Duty To Provide One Time Transition Supply Of Non-Formulary Medicine.
(42 CFR § 423.120 (b)(3))

1. A Medicare Prescription Drug Provider has a duty to provide a one-time transition allotment of a prescribed drug not on its formulary to a new enrollee or if the formulary has been changed without 60 days advance notice, then to someone who was using that medication.

2. CMS Guidance Instructions spell out "suggested extent and nature of duty." Though the Guidance Instructions are vague as to whether this duty requires a one month supply or just enough to get a beneficiary through the exceptions and expedited appeal process.

   a. CMS Guidance Instructions also suggests that nursing home residents be given a 90 day supply of their prior medicine.

B. Right And Procedure To Request An Exception To A Plan's Formulary.
(42 CFR § 423.578)

1. A beneficiary with her physician's support may request an exception or appeal a drug formulary by certifying that a drug prescribed for the beneficiary is better for the individual's medical condition than the ones on the formulary.

2. A beneficiary with her physician's support can also ask for an exception or appeal a drug formulary by certifying that a drug prescribed for the beneficiary would not have the adverse effects on the beneficiary that the ones on the formulary might or have had on the beneficiary in the past.

3. An exception to a basic plan's formulary can also be made by requesting that a higher tier formulary drug should be provided at the basic plan's cost schedule if either 1 or 2 above apply.

4. The plan can request that a physician submit his opinion in writing on the need for the exception.

5. The plan is not bound by the physician's opinion.

6. If the plan does not decide within three days of a request or denies the request then the decision becomes subject to the appeal process.

C. Right To Appeal Formulary And Other Actions Or Inaction Of Medicare Drug Provider.

1. A beneficiary or physician may ask in writing for an appeal of an adverse determination by a drug plan. An appeal can also be requested if a plan has failed to act within 72 hours of a request for an exception to a drug formulary.

2. A beneficiary or a physician may request that the appeal be expedited if a delay in receiving the medication may jeopardize the beneficiary's life, health or ability to regain maximum function. Appeals will not be expedited for recovery of a payment for drugs already furnished.

   a. If the plan determines that the beneficiary has established that waiting the 7 days for a standard appeal decision will result in harm to the enrollee, the plan must expedite the determination and issue it within 72 hours.

   b. If the drug plan does not issue a decision within 7 days of receiving the written appeal request or re-determination, the enrollee can appeal to the Independent Review Entity as if there had been a denial of the appeal and the plan must forward the beneficiary's records within 24 hours.

   c. The plan must expedite either a determination or a re-determination if a physician has supported in writing the request for it to be expedited due to the adverse health consequences to the beneficiary of delay.

3. A beneficiary may file a written appeal request within sixty days of an adverse re-determination by the drug provider. This reconsideration appeal will be conducted initially by the plan, but if not acted on within 7 days (72 hours for expedited reconsideration) then the plan must forward the appeal to a third party under contract with Medicare called an Independent Review Entity.

4. The Part D Independent Review Entity for Ohio is Maximus Federal Services, Part D QIC – PDP Appeals, 1040 First Avenue, Suite 200, King of Prussia, PA., 19406. Phone: 1-458-

688-5600.

5. The Independent Review Entity must issue a decision within 7 calendar days (72 hours if an expedited request) of receiving the written appeal request and sooner if the beneficiary's medical condition requires it.

6. A beneficiary may appeal to an Administrative Law Judge hearing if the IRE decision is adverse within sixty days of receiving the IRE decision.

7. A beneficiary may appeal an adverse ALJ hearing decision to the Medicare Appeals Council within sixty days of receiving the ALJ decision.

8. An adverse Medicare Appeals Council decision may be appealed to Federal Court if the amount in controversy is at least $1130.00.

VI. Medicare Supplemental Insurance

(Act §101 adding §1860 D-13 of the Social Security Act) and (Act §104(a)(1) amending §1882(v) of the Social Security Act)

A. As Of January 1, 2006, Medicare Supplemental Insurance policies, which offer prescription drug coverage (Plans H, I, and J), cannot be sold, issued or renewed to any Medicare beneficiary, who is enrolled or eligible for Medicare Part D.

1. The only exception to the statutory termination of these policies comes with a long list of qualifying conditions and possible penalties for those beneficiaries, who had one of these policies before Jan. 1, 2006 and who choose not to enroll in the Part D program.

2. If their prescription drug coverage under the Medicare Supplemental plan was deemed to be actuarially equivalent to the Part D benefit and they later wished to enroll in the Part D program, they did not have to pay the delayed enrollment penalty of at least 1% per month of delay and did not have to wait for the annual Part D enrollment period to enroll. They had to enroll in the Part D program within 63 days of the loss or voluntary termination of their coverage for reasons other than the non-payment of premiums.

3. If their prescription drug coverage under the Medicare Supplemental plan was deemed not to be actuarially equivalent to the Part D benefit and they later wished to enroll in the Part D program, they had to wait for the annual Part D open enrollment period from mid-November through December 31st of the year and their Part D coverage will begin as of Jan.1st of the following year.

   a. If the prescription drug coverage under their Supplemental plan is deemed to not to be actuarially equivalent then the enrollee will also have to pay a lifetime penalty of at least 1% per each month of delay in not enrolling in the Part D program. This penalty was calculated from May 15, 2006 through the date of subsequent enrollment, i.e. a delay of 18 months, will result in at least an additional 18% monthly penalty on the monthly

premium, a delay 24 months, at least an additional 24% penalty.

b. Medicare Supplemental Insurance companies offering plans H, I, and J had to notify each customer in writing during the period September 15-November 15, 2005:

i. That the coverage under the plan would/would not be considered actuarially equivalent to the Part D benefit.

4. The plans also had to notify their customers that if the beneficiary does not enroll in the Part D plan during the initial enrollment period (November 15, 2005 – May 15, 2006, they would only be able to enroll in Part D after that during the annual enrollment period and would be subject to a monthly late enrollment penalty if they later decided to enroll in Part D Medicare. In addition, they had to tell their customers:

a. That they had a right to reform and continue their Medicare Supplemental policy with the same company without the drug coverage and they would be entitled to a reduction in the policy's premium based on that reformed coverage.

b. That they could also enroll in any other company's A, B, C, or F Medicare Supplemental plan with no pre-existing medical condition limitations or penalties if they apply for that plan within 63 days of enrolling in Part D coverage during the initial enrollment period.

c. That if they did not enroll in Part D and choose to continue their participation in the Medical Supplemental plan with drug coverage and later enroll in Part D, they would lose the right to enroll in another company's Medicare Supplemental Insurance plan without regard to any pre-existing medical condition they may have.

VII. Medicare Advantage Plans.

(Act §101 adding §1860 D-21 of the Social Security Act) and (Act §102 amending §1851 and §1852 of the Social Security Act)

A. New name for the Medicare + Choice HMO, PPO, and PFFS alternative options to traditional Medicare.

1. The Medicare Part D legislation provided between 24 and 60 billion dollars in new money to stabilize and expand these alternative provider options to the traditional Medicare program.

a. These organizations are required to contract to be a Medicare provider on an annual basis.

b. While most of the Act's provisions did not take effect until 1/1/06, the Medicare Advantage Plan (MAP) organizations received their first 10% reimbursement increase in March 2004.

c. These entities must offer at least one plan that has an actuarially equivalent drug benefit

to the Medicare Part D benefit after 1/1/06.

d. In exchange for a much greater reimbursement formula, the MAP organizations must provide:

   i. Some benefit not offered by traditional Medicare, or

   ii. Reduce the present cost to a beneficiary of some service, or

   iii. reinvest the higher reimbursement into stabilizing their provider network, or

   iv. designate a portion of the new funds for some future emergency use.

e. Establishes potential for regional Preferred Provider Organization and HMO options.

   i. Although three different government agencies have issued reports that found Medicare managed care options are being over compensated by 18% to 20%, i.e. traditional Medicare could have served the same population of beneficiaries for 18% to 20% less cost, the new Medicare Advantage Plan organizations are now reimbursed at the same rate as the traditional Medicare program and entitled to the same rate of inflation reimbursement increase each year.

VIII. Changes To Medicare Part B.

(Act §629, 612 and 811 amending §1833, §1861, §1839, and §1844 of the Social Security Act and §6103 and §7213 of the Internal Revenue Code)

A. The Part B Deductible has increased to $131 in 2007.

1. Each year after 2003, the Part B deductible has increased according to the annual growth index for Part B expenditures.

   a. The last change before MPDI & M Act of 2003 in the amount of the Part B deductible was in 1991.

   b. This annual index has yielded an 8% to 10% increase in each of the last four years.

      i. The index used to adjust Social Security benefits has yielded a 1% to 3% annual increase over that same period.

B. On January 1, 2007, the Part B monthly premium will depend on your annual income.

(42 USC 1395r(i)(4)(B))

1. The Part B monthly premium has always been uniformly set by statute to cover 25% of the Part B program's annual cost and each beneficiary paid the same premium each month

regardless of income or assets.

a. As required in the Medicare Modernization Act, beginning in 2007,single beneficiaries with annual incomes over $80,000 and married couples with incomes over $160,000 will pay a higher percentage of the cost of Medicare Part B coverage, , i.e. a graduated rate, thus reducing Medicare's cost share.

b. These higher-income beneficiaries will pay a monthly premium equal to 35, 50, 65, or 80 percent of the total Part B cost, depending on their income level, by the end of the 3-year transition period.

c. For 2007, the higher-income beneficiaries will be responsible for one-third of the income-related monthly adjustment amount. The 2007 Part B monthly premium base rate increased to $93.50 and the other rates are listed in the chart below.

Individual Annual Income	Income Related Monthly Adjustment	2007 Monthly Premium
Up to $80,000	$ 0	$ 93.50
$80,001 to $100,000	$ 12.30	$ 105.80
$100,001 to $150,000	$ 30.90	$ 124.40
$150,001 to $200,000	$ 49.40	$ 142.90
Greater than $200,000	$ 67.90	$ 161.40

d. In 2007, approximately 4 percent of Medicare Part B enrollees with higher incomes will pay a higher Part B premium based on their income. These limits will reduce Medicare costs by an estimated $7.7 billion over the next five years and $20.8 billion over the next 10 years.

    i. This provision went into effect regardless of whether the beneficiary choose to participate in the Medicare Part D program.

e. The Social Security Administration is using 2005 IRS income tax data (adjusted gross income plus tax-free income) to determine a beneficiary's 2007 Part B premium, which means it can be extremely inaccurate as a measure of current income for many recent retirees.

f. The Social Security Administration has developed a form to allow for the correction of inaccurate income data. If a beneficiary had a major life-changing event that has reduced her income, she may use Form SSA-44 entitled: Medicare Part B Income-Related Premium - Life-Changing Event, to request a reduction in her Medicare Part B income-related premium. See http://www.ssa.gov/online/ssa-44.pdf.

i. Through this form, the beneficiary can request that Medicare use a more recent tax year in SSA's calculation of her Part B premium amount.

g. A beneficiary dissatisfied with the calculation or the tax years used may appeal the decision initially through the Social Security appeal process.

i. If still dissatisfied with the Social Security Administration's reconsideration decision, the beneficiary can appeal it to an Administrative Law Judge hearing with the Office of Medicare Hearings and Appeal, then through the Medicare Appeals Council and on to judicial review.

C. New Benefits.

1. New enrollees in Part B now get a free physical examination and diabetes and cardiovascular diagnostic blood screenings not previously covered by Medicare.

IX. Cost Containment Provisions.

(Social Security Act §1817 (b)(2), Social Security Act §1841 (a) and (b) and Medicare Prescription Drug, Improvement and Modernization Act of 2003, §801, §802, §803, and §804)

A. In 2003 Congress, while adding over 670 billion dollars In Part D costs to Medicare's expenditures over ten years, also created a unique and unprecedented "Medicare funding crisis" standard and a mandatory legislative procedure to "solve" the crisis. A "Medicare Funding Warning" is to be issued as a part of the Medicare Trustees Annual Report when the Medicare Trustees' Annual Report projects that federal general revenues (federal taxes and fees) will be needed to pay for 45% or more of the cost of the Medicare program in any one of the following 7 years.

1. The "excess general revenue funding warning" will trigger an expedited submission of a "corrective" plan from the President and crisis consideration of the plan by Congress with the usual rules of Congress suspended for this review and Congressional action.

2. The "corrective plan" adopted must reduce the amount of general revenue funds (primarily federal taxes) used to support the Medicare program below the 45% "funding crisis" standard for each of the following seven years.

3. No other governmental program or agency has such a provision as a part of their funding. Most governmental programs and agencies are 100% funded by federal general revenues.

4. The CBO estimated that the December, 2003 Medicare legislation would cost 395 billion dollars over 10 years while the Medicare agency estimated the 10-year cost at 530 billion dollars. Both are now projecting a ten year cost of over 670 billion dollars.

5. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 provided an

estimated one hundred and eight billion dollar Medicare subsidy for private retiree health plans, shifted responsibility for Medicaid drug coverage for Medicare beneficiaries from the Medicaid program to the Medicare program, greatly increased funding for Medicare Advantage Plans and created a new prescription drug benefit for Medicare beneficiaries. Almost all of these new provisions were to be funded primarily from federal general revenues.

6. The Medicare Trustees' 2004 Annual Report projected that Medicare expenditures will reach this general revenue "crisis" threshold in 2012. (2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds p.9.)

   a. The Medicare Trustees are: the U.S. Secretaries of Treasury, Labor, and Health and Human Services, the Commissioner of Social Security, the Administrator for Medicare and Medicaid Services, and two at large representatives.

   b. If nothing changes the projected proportion of general revenue funding of the Medicare program by 2012 (i.e. increased costs to Medicare beneficiaries or cuts in services covered by Medicare), the 2007 Medicare Trustees' Annual Report will issue a determination of "excess general funding" for the Medicare program around April 1, 2007.

   c. If nothing is done to change the projected proportion of general revenue funding for the Medicare program by 2012 (i.e. increased costs to Medicare beneficiaries or cuts in services covered by Medicare) during 2007, the 2008 Medicare Trustees' Annual Report will issue a Medicare "funding warning" that will trigger the "crisis" provisions of the legislation to reduce general revenue support of the Medicare program below 45 % in each of the seven years after 2008.

   d. The Medicare funding "crisis" will in all probability be announced in early 2008 and this will trigger the "crisis" consideration of legislation under expedited rules to reduce the amount of general revenue support for the Medicare program below 45% in each of the seven subsequent years.

   e. The most likely consequences of this "funding crisis" will be that either more costs will be shifted to Medicare beneficiaries in the form of increased premiums and co-payments or there may be substantial reductions in the benefits promised by this legislation.

   f. Some possible areas of either increasing non-general fund (tax) revenues or reducing major provisions of the new law could be:

      i. The 2007 provisions of the Medicare Part B monthly premiums being determined by income could be changed to include more seniors by lowering the income levels affected from $80,000 to $20,000 or $40,000.

      ii. The subsidy of retiree health insurance plans offering prescription drug coverage

could either be significantly reduced or eliminated.

iii. The drug coverage provisions themselves could be reduced or the deductible, co-payments and the “doughnut hole” could be increased to shift more out of pocket costs onto Medicare beneficiaries.

iv. The prohibition of the Medicare agency to negotiate and purchase medications on behalf of all 43 million Medicare beneficiaries could be eliminated. Some analysts believe that this change would result in about a 40% reduction in the prices beneficiaries and taxpayers would pay for the same drugs purchased under the present program. The House of Representatives passed such a bill in January 2007 and that bill is now awaiting review in the U.S. Senate.

v. Congress could repeal the “Cost Containment” provisions, in other words eliminate their artificially created definition of a Medicare funding “crisis.”

vi. If the planned “crisis” does not result in any changes to the Medicare Act of 2003, it will most certainly result in either Medicare beneficiaries paying more out of pocket or substantial reductions in Medicare coverage and services.