

**MEDICARE PRESCRIPTION DRUG,  
IMPROVEMENT  
And MODERNIZATION ACT OF 2003**

**Copyright © 2005 Pro Seniors, Inc.**

**William C. Hambley, Esq.  
Pro Seniors, Inc.  
7162 Reading Road,  
Suite 1150  
Cincinnati, Ohio 45237  
(513) 345-4160**

# **MEDICARE PRESCRIPTION DRUG, IMPROVEMENT and MODERNIZATION ACT OF 2003**

President Bush signed Public Law 108-173, into law on December 8, 2003. The passage of this Act was the culmination of an eight year battle in Congress over whether Medicare should provide some form of prescription drug benefit and if so how would that benefit be provided.

During the course of those eight years, the real dispute was not about the need to provide some sort of prescription drug assistance, but more about the role the federal government would play in administering the drug benefit and whether the federal government would continue its primary role in administering the Medicare program.

The initial legislation barely passed in the House of Representatives 217-216, and when new provisions were added to it during the House – Senate reconciliation conference, it appeared to have been defeated during the roll call vote on the reconciled bill. The House Majority leader delayed finalizing the results of the vote and permitted a long and protracted lobbying of nay votes by the Administration and other supporters of this legislation. The legislation was finally passed in the House of Representatives 220-215 after a number of earlier nay votes were recast. The initial Senate version of this legislation passed 74-24, but because the reconciliation bill included a number of controversial House of Representative provisions and other provisions that had not been in either of the two bills being reconciled, passed by only a 54-44 vote.

---

## **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 to be delivered by private companies beginning January 1, 2006. Each company will sign a one year contract with the Medicare program.
2. It is expected that each of these companies may offer three or four different drug plans. Each plan will offer additional options to the one plan that is equivalent to the “standard Medicare drug plan”. The options will be based on what drugs are on a particular plan’s formulary and

how much additional out of pocket costs will the older person pay if they choose the “non-standard” plan option.

3. The Medicare agency is prohibited from negotiating drug prices for 42 million Medicare beneficiaries. **Each private, for profit, company will negotiate the price of their drugs on behalf of only their members, a much smaller number of Medicare beneficiaries.** Medicare is also prohibited from even suggesting what a reasonable price would be for a particular drug to the private companies. (§1860D-11(h)(i) of the Social Security Act)
4. To enroll you must have either Part A or Part B Medicare.
5. The Initial Enrollment period is November 15, 2005 – May 15, 2006. An application to enroll in the Medicare drug plan must be sent to one of the private companies approved by Medicare. These companies will be announced in October 2005.
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 the traditional Medicare program.
7. Medicare Advantage plans (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. It is anticipated that about seventy per cent of the Medicare drug plans will be offered by managed care companies. To enroll in these drug plans, a beneficiary would have to leave the traditional Medicare program and receive all of his health care from the managed care company.
8. There must be at least two qualifying plans from two different sponsors or the Medicare program is to offer a limited risk or a no risk fall back option where the Medicare program assumes the risk of non-profitability for a private company.
9. Medicare is authorized to “assume” the risk of unprofitability for a private company providing “fall back” coverage in a service area.
10. **Even in the situation of the “fall back” provider, where Medicare is providing a risk free opportunity, Medicare is prohibited from negotiating or suggesting the price to be paid by the company to the drug manufacturers and pharmacies.** Medicare is also prohibited from contracting with just one company to provide a fallback plan needed throughout the United States.

#### **B. Coverage Provided.**

1. **Plans may use formularies or cover only “approved drugs” as long as the Plan covers at least two medications in a “therapeutic or illness group.”**
2. **Plans may also change the drugs on their formularies upon sixty days advance notice**

**to their members, physicians and the Medicare agency except during the first sixty days of 2006.**

3. **A beneficiary purchasing a non-formulary medication, who does not successfully appeal the formulary's application to them, will receive no Medicare 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 will have a right to appeal a medication that is not on the formulary if they can obtain a doctor's certification that the medicine being prescribed is better for the patient's medical condition than the two offered on the formulary or that the ones offered on the formulary will affect the patient adversely.
5. Plans may use a tiered formulary, where a drug may be on a higher cost formulary, and if a beneficiary wants that particular drug he/she will have to pay the extra cost above that of the Medicare drug program unless they can successfully appeal and show that the drug is superior to the ones on the "Medicare" formulary for their medical condition.
6. Plans may also offer "actuarially equivalent" benefits to the standard plan. Plans will have a great deal of freedom with how to structure their "equivalent" benefits.
  - a. Seniors trying to compare several "actuarially equivalent" plans will have a very difficult time evaluating the plans.
  - b. This is especially true since the different plans have been given a great deal of freedom and discretion in selecting the drugs that will be covered by the Medicare benefit in their formularies.

### **C. Standard Benefit.**

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

1. The specific amount of the monthly premium is not set forth in the statute.
  - a. The Congressional Budget Office "estimated" about a \$35 a month premium as the beneficiary's 25.5 % share of the national average standardized bid amount for 2006.
  - b. Each year this monthly premium will increase by the rate of increase in the overall cost of the Part D program.
2. There is to be a \$250 deductible.
  - a. **Only expenditures for "plan approved" or "covered" medications count towards the deductible.**
3. The plan is to pay 75% (\$1500) of the cost of the next \$2,000 of **"plan approved" or**

**“covered” medications.** The beneficiary has a 25% co-payment for the covered medication.

4. There is no drug coverage for the **next \$2,850 of “covered” medication expenses.**
5. Once a senior, has incurred \$3600 in out of pocket costs of “covered” medications, the plan will pay 95% of the cost of any additional “covered” drugs in that year.
6. The \$3600 out of pocket costs does not include the cost of the Part D monthly premium the beneficiary has to pay for this coverage.
7. **Of the first \$5,100 in “covered” medication expenses (not counting the monthly Part D drug premium), Medicare will pay a maximum of \$1,500.**

#### **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 2006, a beneficiary may change their provider enrollment once during the first six months of the year.**
2. After 2006, beneficiaries will be permitted to disenroll from their drug plan and enroll in a new drug plan during the six week open enrollment period beginning on November 15<sup>th</sup> and may change that decision only once only during the first three months of the following year. Disenrollment after this time will only be approved on a very limited basis until the next November open enrollment period.
3. 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 in a therapeutic group.
4. A substantial new illness or medical condition might require expensive medications not on your 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.
5. For a beneficiary with a \$5,100 out of pocket drug bill, Medicare would pay a maximum of \$1500.00 for “covered medications” only. The beneficiary would pay \$3600 in deductibles and co-payments and would also pay the additional monthly premium for this coverage.
6. Medicare is prohibited from negotiating drug prices on behalf of the 42 million beneficiaries enrolled in the Medicare program. **Each private, for profit, company will therefore negotiate the price of the drugs they will offer only on behalf of their members, a smaller group of Medicare beneficiaries.** Medicare is also prohibited from even suggesting what a reasonable price should be for a particular drug.

**E. Voluntary.**

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

1. **There will be at least a 1% per month, lifetime penalty for each month of delay in enrolling in the program after the initial enrollment period ends on May15, 2006.**
  - a. **Delay 7 months; there will be at least a 7% per month additional lifetime penalty (24 month delay, at least a 24% penalty) added on to each of your monthly Part D premiums. The cost of this penalty in dollars will increase as the monthly premiums increase from year to year.**
  - b. **In addition, the next open enrollment period will not be until November 15, 2006 through December 31, 2006.**
2. If you have both Medicaid and Medicare, Medicaid will no longer pay for your prescription medications. You will have to get your prescription medications through this new Medicare Drug program or go without your medicines. Approximately 6.2 million seniors will have to give up their Medicaid drug coverage.
3. If you are in an 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, you will not be subject to the late enrollment penalty if you enroll in Part D 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 \$250 and \$5,000.**
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 15<sup>th</sup> and November 15<sup>th</sup> 2005.
- 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 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 not as good as the Part D benefit.**

**C. The amount of each individual's 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 in 2005 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 \$5100 in prescription drug costs under the new Medicare Part D program, a senior will pay \$3600 in co-payments and deductibles for "covered" medications and Medicare will pay a maximum of \$1500.
  - b. The Part D benefit provides no coverage for a beneficiary for the out of pocket cost of drugs between \$2,250 and \$5,100.
  - c. If a retiree plan now pays 80% of prescription medication costs with a 20% co-payment benefit, in 2006, the retiree plan could reduce their 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 drug payments **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 eighth 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 2006. This number represents about 30 per cent of the 11.5 million retirees, who have some prescription drug coverage currently.

**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. On Jan. 1, 2006, Medicaid programs will no longer receive federal matching funds for the purchase of prescription medications for individuals, eligible for both Medicare and Medicaid.**

1. The Secretary of HHS was required to develop a plan to automatically enroll in the new Medicare Prescription Drug program all individuals on Medicaid, who also have Medicare,
  - a. Approximately 6.2 million seniors will be affected.
  - b. During October 2005, the Secretary will send notices to all Medicaid recipients advising them of which company's drug plan he has enrolled them in unless the recipient chooses another plan before December 31, 2005.
  - c. The Secretary's assignment of plans to Medicaid beneficiaries will be a blind rotation assignment and therefore many Medicaid recipients may be assigned to drug plans that do not have their medications on their formularies.

**B. Presently, Medicaid programs must provide coverage for all FDA – approved drugs of every drug manufacturer that has agreed to pay rebates to the states.**

1. The for - profit companies that will provide the Medicare prescription benefit are permitted to offer as few as two drugs in any given therapeutic class.
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 they successfully appeal the company's drug formulary's application to them.

**C. Most Medicaid recipients with incomes of 100% of poverty level or less must pay a co-payment per prescription of \$1/ generic and \$3 / brand name drug. These co-payments will also increase each year by the increased cost of inflation for medications.**

1. Nursing home residents on Medicaid will not have to pay these co-payments, but will have to switch from the Medicaid to the Medicare Prescription Drug program.
2. Nursing home residents will have to review and choose one of the companies that will provide the Prescription Drug benefit and will be subject to all of the choice and access limitations that are a 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 will provide premium and cost sharing subsidies for certain low-income eligible individuals.**
- 1. People eligible for Medicaid and Medicare will pay no premium or deductible and will not have the \$2,850 doughnut hole gap in their coverage. They will have to pay \$1 per prescription for generics and \$3 for brand named drugs.** These co-payment amounts will be subject to annual inflation increases. This group will be automatically enrolled in a Part D plan and determined eligible for this subsidy as of January 1, 2006
    - a. Those automatically enrolled in a drug plan may not be assigned a plan that covers their medicines. They will have the right to pick a different plan.**
    - b. People, who are also on the State Medicare Buy In programs, the SSI program or who have monthly income of \$803 a month or less and who have no more than \$6,000 (\$9,000 married couple) in liquid assets will be eligible for the full low income subsidy and also have no monthly premium, deductible or co-payment gap in their coverage.** They will have to pay \$1 for each covered generic drug and \$3 for each covered brand name drug. They will be automatically enrolled in a Part D plan as of June 1, 2006 if they have not chosen one by May 15, 2006.
  - 2. Individuals with monthly incomes below \$1,083 (couple below \$1,463) and liquid assets of \$6,000 (\$9,000 for married couples) will pay no premium or deductible and have no gap in their coverage.** They will pay \$2 for each generic and \$5 for each brand name covered prescription.
  - 3. If your monthly income is \$1,083 (\$1,463 - two people) or less and you have liquid assets of \$10,000 or less (\$20,000 – married couple) but above \$6,000 single, (\$9,000 - married couple), you will not have a monthly drug premium. You will have a \$50 deductible and no coverage gap. You will have to pay a 15% co-payment on covered medicines.**
  - 4. If your monthly income is between \$1084 - \$1204 singles (\$1,463--\$1,625 – two people) and you have liquid assets of \$10,000 or less (\$20,000 - married couple) you will have a \$50 deductible and no \$3600 coverage gap. You will have a 15% co-payment on covered medicines. You will also have a sliding scale monthly drug premium (from \$0 - \$37) depending on your income.**
    - a. The maximum monthly income to qualify for a partial drug subsidy benefit in 2006 is \$1,204 for an individual and \$1,625 for a couple.**
    - b. The maximum annual income for a single person to qualify for a partial drug subsidy benefit in 2006 is \$14,355. 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 \$19,245 in 2006.**

**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 because work expenses will be subtracted first from the total income.
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 home you live in, your furniture or furnishings, your automobile and your wedding ring and other jewelry,
  - a. If you promise to use up to \$1500 in savings for your funeral, it will not be counted even though it may be in your 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 you live with one of your children, Social Security will only look to the value of your assets only.

**D. Applications for the Medicare Prescription Drug Low Income Subsidy should be made to the Social Security Administration and local Social Security offices. The Social Security Administration is responsible for distributing and processing applications for the low income subsidies.**

1. These applications will begin to be processed in July of 2005 and notices of approval and denials will be sent to each applicant as they are processed. 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 their formulary to a new enrollee or if the formulary has been changed without notice to someone, who was using that medication.
2. CMS Guidance Instruction of March 16, 2005 spells out “suggested extent and nature of duty. Vague as to whether duty requires a one month supply or just enough to get beneficiary through the exceptions and expedited appeal process.
  - a. CMS Instruction “suggests” that nursing home residents be given a 90 – 180 day supply of their prior medicine.

**B. Right To Request Exceptions And Process.**

(42 CFR § 423.578)

1. A beneficiary or physician may ask for an exception to a drug formulary if a drug prescribed for the beneficiary formulary is better for the individual’s medical condition than the ones on the formulary.
2. A beneficiary or physician may ask for an exception to a drug formulary if a drug prescribed for the beneficiary will 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 be provided at the basic plan’s cost schedule if either 1 or 2 above apply.
4. The company can request that a physician submit his opinion in writing on the need for the exception.
5. The company is not bound by the physician’s opinion.
6. If the company does not decide within three days of 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 drug plan has failed to act within 72 hours on a request for an exception to a drug formulary.
2. An enrollee or a physician may request that the **appeal** be **expedited** if a delay in receiving the medication may jeopardize the enrollee’s life, health or ability to regain maximum function. Appeals do not have to be expedited for payment of drugs already furnished.

- a. If the drug plan determines that the enrollee 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 request for an appeal 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 enrollee's records within 24 hours.
  - c. The plan must expedite either a determination or a redetermination if a physician has supported in writing the request for it to be expedited due to the adverse health consequences to the enrollee.
3. An enrollee 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 Independent Review Entity for Ohio is the Center For Health Dispute Resolution, P. O. Box 5042, New York, New York 10274-5042. Phone - **1-800-567-0757**.
  5. The Independent Review Entity must issue a decision within 7 calendar days (72 hours if expedited request) of receiving the written appeal request and sooner if the enrollee's medical condition requires it.
  6. An enrollee may request an appeal for an Administrative Law Judge hearing if the IRE decision is adverse within sixty days of receiving the IRE decision.
  7. An enrollee 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 \$1050.00.

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

1. The only exception to this 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 is **deemed to be actuarially** equivalent to the **Part D benefit** and they later wish to enroll in the Part D program, they will not have to pay the delayed enrollment penalty of at least 1% per month of delay and will not have to wait for the annual Part D enrollment period to enroll. They will have 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 is deemed to **not** be actuarially equivalent to the Part D benefit and they later wish to enroll in the Part D program, they will have to wait for the annual Part D enrollment period from mid-November through December 31<sup>st</sup> of the year and their Part D coverage will begin as of Jan.1<sup>st</sup> 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 will be calculated from May 15, 2006 through the date of subsequent enrollment. (delay 18 months, at least an additional 18%monthly penalty on the monthly premium, delay 24 months, at least an additional 24% penalty)
  - b. The statute strongly implies that these plans are not equivalent to the Part D coverage. The Secretary of Health and Human Services has also publicly stated that these plans are not as good as the Part D coverage.
  - c. Medicare Supplemental Insurance companies offering plans H, I, and J must notify each customer in writing during the period of September 15-November 15, 2005:
    - i. That the coverage under the plan will **not** be considered actuarially equivalent to the Part D benefit.
4. The plans must also 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 will only be able to enroll in Part D after that during the annual enrollment period and will be subject to a monthly late enrollment penalty if they later decide to enroll in Part D Medicare. In addition, they must tell their customers:**
  - a. That there is a right to reform and continue their Medicare Supplemental policy with the same company without the drug coverage and they will be entitled to a reduction in the policy's premium based on that "reformed" coverage.
  - b. That they can 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 do 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 will 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.**

(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. Provides between 14 to 60 billion dollars in new money to "stabilize" and expand these alternative provider options to the traditional Medicare program.
  - a. These organizations will still only be required to contract to be a Medicare provider on an annual basis.
  - b. While most of the Act's provisions do not take effect until 1/1/06, the Medicare Advantage (MA) organizations received their first 10% increase in reimbursement in March 2004.
  - c. No new protections for Medicare beneficiaries from for - profit entities utilizing discriminatory pricing and usage policies to discourage chronically ill or very sick seniors from enrolling or remaining in these organizations.
  - d. No requirement that these entities offer a prescription drug benefit of any kind in 2004 and 2005. However, they must offer at least one plan that has an actuarially equivalent drug benefit to the Medicare Part D benefit after 1/1/06.
  - e. In exchange for a much greater reimbursement formula, the MA organizations must provide: a) some benefit not offered by traditional Medicare, or b) reduce the present cost to a beneficiary of some service, or c) reinvest the higher reimbursement into stabilizing their provider network, or d) designate a portion of the new funds for some future emergency use.
  - f. Establishes potential for regional Preferred Provider Organization and HMO options.
    - i. Although three different government agencies have issued reports that have found that Medicare + Choice options are being over compensated by 18 to 20% more than it would have taken the traditional Medicare program to serve the same population of beneficiaries, the new Medicare Advantage organizations will now be reimbursed at the same rate as the traditional Medicare program and entitled to the same rate of inflation increase in reimbursement 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 will increase from \$100 to \$110 for 2005.**

1. Each year thereafter, it will increase according to the annual growth index for Part B expenditures.
  - a. The last change 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 time period.

#### **B. On January 1, 2007, the Part B monthly premium (\$78.20 in 2005) will depend on your annual income.**

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. Individual seniors with annual incomes of \$80,000 (\$160,000 for couples) will begin to pay a higher monthly premium depending on their income, i.e. a "graduated rate."
    - i. Individuals with \$80,000 annual income (couples with \$160,000) will pay a 10% per month higher premium.
    - ii. Individuals with \$100,000 annual income (couples with \$200,000) will pay twice the monthly premium paid by those under \$80,000.
    - iii. Individuals with \$200,000 annual income (couples with \$400,000) will pay a little over three times the monthly premium as those whose income is under \$80,000.
  - b. This change affects only a very small group of Medicare Beneficiaries and is expected to bring in only 1 to 1 ½ billion dollars over 10 years.
    - i. Many commentators and advocates believe the annual income limits were set high in order to establish the principle that the amount of one's Part B premium in the future will depend on a person's annual income
      - These critics cite a number of the cost containment provisions in the legislation

that provide for expedited action by Congress where the usual Congressional rules of procedure can be suspended. The 2004 Medicare Trustee's Report projects that these cost containment "crisis" provisions will be triggered in the Spring of 2006. (p. 9, 21, 29, 30, and 149 of the 2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds)

- 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.
- ii. To generate substantial income for the Medicare program the annual income based Part B premium would have to begin in the \$20,000 - \$40,000 annual income range.
- iii. This provision will go into effect regardless of whether the senior (or couple) chooses to participate in the Medicare D pharmacy program.

### **C. New Benefits.**

1. New enrollees in Part B will 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. While adding over 855 billion dollars to Medicare's expenditures over ten years, Congress 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 more than 45% of the cost of the Medicare program in any one of the next 7 years will come from federal general revenues.**

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 850 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 the Medicare Advantage HMO options and created a new prescription drug benefit for Medicare beneficiaries. Almost all of these new provisions are 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. 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 2006 Medicare Trustees' Annual Report will issue a determination of "excess general funding" for the Medicare program around April 1, 2006.
  - b. 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 2006, the 2007 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 2007.
  - c. The Medicare funding "crisis" will in all probability be announced in early 2007 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.
  - d. 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.
  - e. 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 a lot more seniors by lowering the income levels to be affected from \$80,000 to \$20,000 to \$40,000 a year.

- 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 42 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.
- v. The 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.