SUMMARY OF MEDICARE ACT OF 2003

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On December 8, 2003, President Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003; Public Law 108-173 (Medicare Act of 2003). This legislation includes sweeping changes to the Medicare program. It will provide Medicare beneficiaries with some limited assistance paying for prescription drugs. The legislation also extends some programs, and begins others, which will be helpful to Medicare beneficiaries. However, the Medicare Act of 2003 also includes major restructuring of the traditional Medicare program, relying heavily on private insurance for the delivery of benefits. In addition, it increases beneficiary cost sharing responsibilities.

I. PRESCRIPTION DRUG PROGRAMS

Prescription Drug Discount Card:

On December 15, 2003, CMS published interim final rules with a comment period to implement the Medicare prescription drug discount program created by the Medicare Act. 68 Fed. Reg. 69840 (Dec. 15, 2003). Eligible Medicare beneficiaries will be able to enroll in one discount drug card approved by CMS starting in May 2004. The discount drug cards will become effective in June 2004. Card holders will have access to discount prices negotiated by their drug card for prescriptions that are included in the card's formulary. The prescriptions that are covered and the price of each covered prescription will vary, depending on the card, and each discount card program can change its formulary at any time. Card holders will be able to use the cards at pharmacies included in the card's network that dispense the covered discount card drugs at the negotiated price. Pharmacies are supposed to be conveniently located.

An eligible individual is someone who is entitled to benefits under, or enrolled under Part A, or enrolled under Part B. Individuals who are entitled to drug coverage under a state Medicaid program or through a §1115 waiver may not purchase a card. Individuals enrolled in a state Medicaid program or in a waiver program that *does not* provide drug coverage may purchase a discount card if they are otherwise eligible for the program. Similarly, "medically needy" individuals who qualify for Medicaid based on a spend-down or other method of eligibility may purchase a discount card if, at the time of applying for the discount card program, they otherwise meet its eligibility requirements. The regulations further specify that once any individual is found eligible for the program he will remain eligible unless he chooses to disenroll.

The Medicare Act and interim final regulations provide for continuous open enrollment for the duration of the program, which expires on December 31, 2005. Once they have selected a discount card in which to enroll, enrollees will not be able to change the card until the next year without exceptional circumstances, such as moving outside the card's service area. Someone who voluntarily disenrolls from the program may not enroll in another endorsed discount drug card until the annual coordinated enrollment period in November. Discount drug cards may charge an annual enrollment fee not to exceed $30.00. CMS is required to provide information in May 2004 comparing the annual enrollment fees and other plan features. CMS' material will include information on the variability of discounts on prices of covered discount card drugs under the endorsed program and the fact that individuals may only enroll in one card.

The Act provides additional assistance for a "transitional assistance eligible individual" and for a "special

transitional assistance eligible individual." The former group includes individuals whose income is not more than 135% of poverty and who do not have coverage under a group health plan or health insurance coverage; insurance related to uniformed services; or federal employees' health benefits program. A "special transitional assistance eligible individual" is a discount card eligible individual whose income is not more than 100% of poverty. Individuals who apply for this assistance self-certify their income, family size, and other prescription drug coverage available. CMS then verifies the information. Individuals who qualify for Medicare Savings Programs (QMB, SLMB, QI-1) may be deemed to meet the eligibility requirements for transitional or special transitional assistance.

Individuals in both of these categories will have payment made for their annual enrollment fees. A transitional assistance eligible individual will have payment available for 90% of costs incurred for *covered discount card drugs* obtained through the program. Payment is available for up to $600 of costs in 2004. Any leftover money carries over to 2005, when the individual becomes eligible for an additional $600. If the enrollee qualifies as a special transitional assistance eligible individual, he is entitled to payment of 95% of costs incurred, and payment is available for up to $600 in costs.

States have the option of paying the enrollment fee for individuals who do not qualify for transitional or special transitional assistance. States may also ask CMS for permission to pay, with state-only funds, co-insurance amounts for transitional and special transitional individuals. Pharmacies may also waive the co-insurance amount for these individuals.

Prescription Drug Benefit:

The Medicare Act creates a new Medicare Part D under which individuals eligible for either Part A or Part B may obtain qualified prescription drug coverage either through a stand alone prescription drug plan (PDP) or through a Medicare Advantage plan (MA-PD). Such plans would be offered in regions developed by CMS that correspond to regions for managed care plans. Coverage under the voluntary benefit begins on January 1, 2006.

Unlike Part B, enrollment is in a drug plan, not in the Part D benefit. The initial enrollment period will be November 15, 2005 through May 15, 2006. Individuals who first become eligible for Part A after that date will have an enrollment period that corresponds with their Part B enrollment period. People who do not enroll during the initial enrollment period will have the opportunity to enroll during an annual enrollment period that corresponds to the enrollment period for Medicare managed care plans. There will also be special enrollment periods for individuals who move out of a service area or who lose comparable coverage under an employer plan, Medicaid, or other plan (but not under Medigap policies H, I, J.) Individuals are generally "locked in" to the plans in which they enroll until the next annual enrollment period, which runs from November 15 through December 31. However, individuals who enroll in an MA-PD may be able to make one change to another MA-PD or to original Medicare and a PDP during the first three months of the year.

Failure to enroll when originally eligible to choose a Part D plan will result in the imposition of a penalty that has the potential of being substantial. The penalty will be the greater of an amount that is actuarially sound for each uncovered month or one percent of the national average monthly beneficiary base premium for each uncovered month. It is unclear whether, in determining an amount that is "actuarially sound," the health status of each individual late enrollee may be taken into consideration. This would have the effect of medical underwriting of the policy. Someone who loses coverage in the middle of the year but who does not qualify for a special election period would incur a penalty while waiting until the annual coordinated

enrollment period to enroll in another plan.

The benefit design may vary from plan to plan and from geographic location to geographic location. The $35 monthly premium is not statutory and is only an estimate of the projected average premium; actual premiums may be higher. The Medicare Act specifies that the standard benefit package for 2006 include a $250 deductible, 25% cost sharing on formulary drugs for costs from $251 - $2250 full beneficiary payment (doughnut hole) from $2251 - $5100, and catastrophic coverage from $5100 with a 5% co-payment (beneficiary incurs $3600 in out-of-pocket expenses.) Under the Act all figures are indexed for future years. However, plans may vary the benefit design as long as the package is "actuarially equivalent" and they do not raise the deductible or change the out-of-pocket threshold. Thus, a plan may charge varying co-payments depending on therapeutic class of drugs, charging higher co-payments for some more expensive classes of drugs or drugs used by people with chronic conditions. Only out-of-pocket expenses for formulary prescriptions count in determining the $3,600 threshold for catastrophic coverage. Expenses for an off-formulary drug are not included in the calculation.

Both a PDP and an MA-PD may offer supplemental coverage to the basic benefit. It is more likely that an MA-PD, rather than a PDP, will offer such coverage because of the overpayments to managed care plans included in the Act. In addition, because an MA-PD covers the full range of Medicare benefits, it has more flexibility in its benefit design than a PDP does and can take greater steps to prevent supplemental drug coverage from attracting enrollees with more chronic conditions. For example, an MA-PD plan can impose higher cost-sharing for such services as home health care and hospital care to discourage enrollment of individuals with chronic conditions who are more likely to use supplemental drug coverage.

Each plan may develop its own formulary and definition of therapeutic class in which drugs are to be included. There are no federal standards or requirements. Plans may only change therapeutic class definitions once a year, but it appears they may be able to change the drugs covered within a therapeutic class or change preferred or tiered co-payment status of a drug more frequently. Notice of changes must be *made available, not provided*, to enrollees, physicians, and others. The statute requires plans to have a "mechanism" for providing timely information to enrollees upon request, including the use of a toll-free telephone number or provision of information in writing. The plans must also make information about formulary changes available on a timely basis on their web site.

Plans cannot require beneficiaries to use mail-order services, but they may charge lower co-payments or allow larger supplies of drugs for those who do so. Plans may also impose higher co-payments for prescriptions filled at out-of-network pharmacies.

The Medicare Act "guarantees" beneficiaries access to two plans which could be two PDPs or one PDP and one MA-PD. The two plans must be offered by different entities. A government-approved "fallback" plan may be available if no plans come into the region or if there is only one PDP or only one MA-PD. While a sponsor can offer a national MA-PD, no sponsor can offer a national fallback plan. There is some concern that the choice of plans may be more limited than the guarantee indicates, however, since a fallback plan is allowed to be offered in a limited "area" within a "PDP region."

Plans, other than fallback plans, may send marketing materials to people eligible for Part D. Since CMS will provide "identifying information" to the private plans, these plans could limit their marketing to certain parts of a region or to certain individuals in a region. CMS is supposed to send information to beneficiaries about plans available to them at least 30 days before the enrollment period. The information will include benefits provided under the plan, the monthly premium, quality and performance and consumer satisfaction surveys

where available, and beneficiary cost-sharing. The statute does not require CMS to send information about the drugs covered under each plan's formulary and the cost of each drug.

The statute requires a PDP or MA-PD to have an appeals process that is the same as the process for managed care plans. In doing so, the statute seems to distinguish between coverage determinations and redeterminations that would go through the internal plan process and appeals that would go through the external (currently with the Center for Health Dispute Resolution) and administrative law judge levels of review. Other potential problems include issues of notice of denials and appeal rights, timeliness, including expedited review, and jurisdictional amounts. In addition, the statute says ".... only the Part D eligible individual shall be entitled to bring such an appeal..." calling into question the ability of a guardian or other agent to act on an individual's behalf. The provision also directly precludes a physician from acting on the individual's behalf as occurs in many state Medicaid programs.

A beneficiary enrolled in a plan with tiered co-payments can go through the internal review process to request that a non-preferred drug be covered in the same way as a preferred drug. The prescribing physician must determine that the plan's preferred drug for the treatment of the same condition is not as effective for the beneficiary or would have adverse effects for the beneficiary. An adverse determination could be appealed further through external and ALJ review. However, the statute seems to indicate that a beneficiary would have to start at the external review and ALJ appeals process, rather than the more expeditious internal process, to get coverage for a non-formulary drug.

In addition, the prescribing physician must determine that all covered drugs on any tier of the plan's formulary for treatment of the same condition would not be as effective for the individual or would cause adverse effects or both. Because out-of-pocket expenses for non-formulary drugs are not counted towards the $3,600 out-of-pocket cost sharing limit, the need for an expeditious process to allow beneficiaries to get coverage for off-formulary drugs takes on double significance.

Controlling the Cost of Prescription Drugs:

The Medicare Act precludes the Secretary of Health and Human Services (HHS) from negotiating drug prices on behalf of the almost 41 million Medicare beneficiaries. Each PDP and MA-PD will negotiate on its own behalf. The Act also places restrictions on the ability to reimport pharmaceuticals from Canada and other countries. Thus, it does not appear that the legislation adequately addresses the problem of uncontrolled increases in the price of prescription drugs.

Prescription Drug Coverage for Low-income Individuals:

The Medicare Act distinguishes between people who are dually eligible for Medicare and full Medicaid and other low-income individuals and provides assistance for both groups.

Dual eligibles enrolled in a Part D plan who are institutionalized pay no premium, no deductible, no co-insurance and have no gap in coverage. The Secretary of HHS has authority to develop standards concerning access to pharmacy services for people in nursing facilities.

Dual eligibles enrolled in a Part D plan with incomes up to 100% of poverty who are not institutionalized pay no premium, no deductible, have no gap in coverage and pay co-payments of $1 for generic/preferred drugs and $3 for other drugs in 2006. All other dual eligibles enrolled in a Part D plan have no premium, no deductible, no gap in coverage. They pay co-payments of $2 for generic/preferred drugs and $5 for other

drugs in 2006. Co-payments for all dual eligibles are indexed to the increase in the price of covered drugs in future years and end when the individuals have spent $3600 out-of-pocket. Individuals enrolled under a Section 1115 waiver program appear *not* to be included in the definition of dual eligibles, thus making them eligible under the non-Medicaid categories, instead.

Unlike with other Medicaid benefits, Medicaid is prohibited from providing "wrap-around" coverage for Part-D covered drugs that are not included in a PDP's formulary or for the co-payments dual eligibles must pay. States *may*, but are not required to, pay for drugs that are covered in their Medicaid plan but that are not Part D covered drugs. Thus, there is no Medicaid drug coverage for an individual *eligible for* a Medicare drug plan, regardless of whether the individual is enrolled in such a plan. In other words, although Part D is voluntary for most Medicare beneficiaries, it does not appear to be voluntary for those with full Medicaid coverage who want continued prescription drug coverage. The Secretary is authorized to enroll in Part D plans dual eligibles who have not so enrolled, but it is not yet clear how this will be accomplished, raising concerns that some individuals may lose drug coverage. The prohibition against wrap-around services appears not to apply to those enrolled in Medicaid under a Section 1115 waiver.

Individuals without full Medicaid benefits who are enrolled in a Part D plan, who have incomes up to 135% of poverty, and whose countable assets are less than $6,000/individual or $9,000/couple pay no premium, no deductible and have no gap in coverage. They pay co-payments of $2 for generic/preferred drugs and $5 for other drugs in 2006. Individuals without full Medicaid benefits who are enrolled in a Part D plan, who have incomes up to 150% of poverty, who are not eligible under other low-income categories and whose countable assets are less than $10,000/individual or $20,000/couple, pay a sliding scale premium from $0-$420 and a $50 deductible. There is no gap in coverage. They pay cost-sharing of 15% (reduced from 25%) up to the catastrophic threshold, with $2 (for generic/preferred drugs) and $5 (for other drugs) co-payments after they spend $3600 out-of-pocket. Co-payments for future years for both groups are indexed to the price increase in covered drugs. Resource levels for future years are indexed to the Consumer Price Index.

Eligibility is determined either by the state Medicaid agency or by the Social Security Administration (SSA). Eligibility for a low-income subsidy begins in the month in which the individual applies. Appeals and redeterminations made by Medicaid are governed by Medicaid rules; those for determinations made by SSA are governed by SSA's rules. The Secretary of HHS *may* deem Medicare Savings Program recipients (QMBs, SLMBs, QI-1s) who are not eligible for full Medicaid benefits as eligible for the subsidy for individuals up to 135% of poverty and *must* so deem them if the state's rules for MSP eligibility are substantially the same as the federal rules for that subsidy. States must, while determining eligibility for low-income subsidies, screen for eligibility for their Medicare Savings Programs and enroll individuals found eligible.

A state may *not* use its more generous Medicaid rules for counting income and resources in determining eligibility for non-Medicaid low-income subsidies unless HHS determines that their use will not result in significantly more people becoming eligible for the subsidy. Income and resources are determined with reference to the Supplemental Security Income program.

Coordination with State Pharmacy Assistance Programs:

Over 30 states currently provide prescription drug coverage to either older people, people with disabilities, or both populations. In many instances existing state pharmacy assistance programs are more generous and serve more people than the Medicare drug benefit. Payments made under state pharmacy assistance

programs count toward the out-of-pocket expenses limit. But PDPs and MA-PDs can prohibit wrap-around benefits by such programs if the benefits would undermine cost-management tools such as tiered co-payments and limited formularies. In addition, state pharmacy assistance programs may have their own requirements that may raise questions about the ability of individuals to enroll in both programs. For example, a state may limit eligibility for its program to those for whom no other plan of insurance or assistance is available.

Medigap Prescription Drug Coverage:

On the day that Medicare Part D goes into effect, Medicare Supplemental Insurance (Medigap) plans that cover prescription drugs (Plans H, I, and J) cannot be sold, issued or renewed to any Medicare beneficiary who is enrolled in or eligible for Medicare Part D - with one exception. The exception is that a Medigap policy with prescription benefits issued *before* January 1, 2006, may be renewed for a person *not* enrolled in Medicare Part D.

Under the new law, beneficiaries who currently have Medigap prescription drug plans will be guaranteed issuance of Medigap plans A, B, C, or F. These individuals will have no waiting period for coverage of pre-existing conditions and no medical underwriting if they enroll in a Part D plan during the initial Part D enrollment period and seek to enroll in the new Medigap policy within 63 days of the effective date of their coverage under Part D. Beneficiaries who drop a Medigap prescription drug plan to enroll for the first time in a Medicare Advantage plan and who subsequently disenroll from Medicare Advantage within 12 months are also guaranteed re-issuance of their Medigap prescription drug plan if it is still available from the original issuer. If not, they are guaranteed issuance of other Medigap plans A, B, C, or F with no wait for coverage of pre-existing conditions and no medical underwriting. Beneficiaries must enroll in the Medigap plan within 63 days of the effective date of disenrollment from the Medicare Advantage plan.

If a beneficiary decides to keep his Medigap prescription drug plan, upon enrollment in Medicare Part D the Medigap plan's coverage will be modified to eliminate prescription drug coverage for expenses of prescription drugs incurred after the effective date of coverage under Part D. Premiums will also be adjusted to reflect the elimination of this coverage. Someone who delays enrollment in a Part D plan because he had a Medigap prescription drug plan (plan H, I, or J) will be subject to a late enrollment penalty. A Medigap prescription drug plan does not qualify as a PDP or qualify as providing an equivalent benefit to the basic Part D drug benefit.

Two new Medigap policies will also be offered. The first benefit package will cover 50% of cost-sharing applicable under Medicare Parts A and B, except for the Part B deductible. It will cover 100% cost-sharing for preventive benefits, all inpatient hospital co-insurance, and 365 extra lifetime days of coverage of inpatient hospital services. There will also be a limitation on annual out-of-pocket expenses under Parts A and B of $4000 in 2006, which will be adjusted for inflation in subsequent years. The second benefit package will be the same as the first except that it will cover 75% of cost-sharing applicable under Parts A and B and the limit on annual out-of-pocket expenses will be $2000 in 2006.

Neither the existing nor the new Medigap policies will cover any of the cost sharing associated with the prescription drug benefit provided under Part D.

II. BENEFIT AND STRUCTURAL CHANGES

Restoration of the Moratorium on Therapy Caps:

Effective December 8, 2003, physical, speech, and occupational therapy performed in an outpatient setting will not be subject to the financial caps imposed by the Balanced Budget Act of 1997. Thus, beneficiaries may continue to receive medically necessary therapy services, ordered by their physicians, regardless of the cost incurred. The moratorium continues to be in effect until the end of December 2005.

Extension of QI-1 Program:

The Medicare Act extends, through September 30, 2004, the QI-1 program, which was last authorized through March 31, 2004. The QI-1 program requires state Medicaid programs to pay the Medicare Part B premium for individuals who are not otherwise eligible for Medicaid and who have incomes between 120-135% of federal poverty levels. The states receive 100% federal money to cover the costs of this benefit, i.e., there is no requirement for a state match. However, the total amount of money is capped, so that if a state uses up its allotment, it has no further obligation to serve additional applicants for the benefit. President Bush's fiscal year 2004 budget includes a reauthorization of the QI-1 program for five years.

Potential for Increased Managed Care Options in 2004:

The first payment increase for Medicare managed care plans included in the Medicare Act takes effect March 2004. As a result, HMOs in some parts of the country may improve the benefits they offer or reduce their premiums or cost-sharing. At least one HMO in the Philadelphia area has already announced it will now offer a "zero-premium" plan. Instead of using the increased financing to improve benefits, the plans may also increase provider payments or set the money aside in a benefits stabilization fund. The provision increasing reimbursement also allows organizations that terminated their Medicare HMO or that reduced the size of their service area as of January 1, 2004, to come back into the areas they left to offer an HMO.

New Preventive Benefits and Services:

The Act provides for Medicare Part B coverage of intravenous immune globulin for the treatment in the home of primary immune deficiency diseases where medically necessary. Coverage begins January 1, 2004.

The Act added coverage for the following preventive benefits for Medicare beneficiaries, starting in January 2005:

- An initial physical exam (it does not cover lab tests) performed within 6 months of a beneficiary enrolling in Part B. If a beneficiary never enrolls in Part B she never gets this exam. Also, this provision is not applied retroactively so only Medicare Part B enrollees after the effective date will get the exam.

- Cardiovascular screening blood test such as a cholesterol (lipids and triglycerides) test once every two years at most. It does provide for the addition of other tests with the Secretary's approval but may be limited to only certain individuals and only with the recommendation of the U.S. Preventive Services Task Force.

- Diabetes screening via a fasting plasma glucose test (other tests as the Secretary deems appropriate). This will be limited to individuals at high risk for diabetes. High risk is defined as having any of the following risk factors: age 65 or older, hypertension, dyslipidemia, obesity (Body Mass Index [BMI] >30), previous identified impaired glucose tolerance, OR at least two of the following: overweight (BMI 25 - 30), family history of diabetes, history of

gestational diabetes, or delivery of baby > 9 lbs. Frequency covered is no more than twice per year.

Potential for Reduced Access to Durable Medical Equipment (DME):

Changes to the way Medicare pays for durable medical equipment may make it more difficult for some beneficiaries to obtain Medicare coverage for these items. The Medicare Act freezes payments for most DME through 2008, and calls for the phasing in of a competitive bidding system for many items starting in 2007. In addition, the Act reduces payment for some of the most common items, including oxygen equipment, wheelchairs, nebulizers, diabetic supplies, hospital beds and air mattresses, starting in 2005, to bring the rates more in line with payments under the Federal Employees Health Benefits Program. Payment rates for therapeutic shoes and inserts will also be reduced in 2005.

Indexing Part B Deductible:

The Part B deductible, which has been set at $100 since 1991, will increase to $110 in 2005. The deductible will then increase yearly by the same increase as the Part B premium, i.e., by the annual percentage increase in the monthly actuarial value of benefits payable under Part B.

Income-Related Part B Premium:

Starting in 2007, individuals with incomes over $80,000 per year and couples with incomes over $160,000 per year will have to pay a greater share of the Part B premium. Rather than paying 25% of the Part B rate, those with incomes of $80,000-$100,000 ($160,000 - $200,000 for couples) will pay 35 % of the Part B rate. People with incomes of between $100,000 - $150,000 ($200,000 - $300,000 for couples) will pay 50% of the rate, and those with incomes above $200,000 ($400,000 for couples) will pay 80% of the rate. The income amounts will be increased yearly by the Consumer Price Index.

The Internal Revenue Service will provide information to the Social Security Administration (SSA) to help identify individuals subject to the income-related increase in their Part B premium.

The Medicare Advantage Program:

The Medicare Act re-titles Medicare+Choice, the current Medicare Part C, to Medicare Advantage (MA), phasing the name change in through 2004 and 2005. In addition to the payment increases for 2004 discussed above, the Act provides for restructuring of the payment rates so that MA plans will be paid increasingly more on average per enrollee than Medicare would pay had the individual remained in the traditional program. Congress intended the increased payments to encourage establishment of more MA plans, particularly in rural areas, and to increase enrollment. Private insurance companies may continue to offer HMOs and private fee-for-service plans under the MA program. The Medicare Act reauthorizes Medicare Savings Accounts (MSAs) as a plan option under Part C, though no company has ever offered a Medicare MSA. Starting in 2006, only local PPOs in the current PPO demonstration areas will continue to be authorized. Instead, private insurance companies will be able to offer regional plans, primarily PPOs, in one of the 10 to 50 regions to be established by HHS. The Act provides significant financial assistance to encourage private insurance companies to offer regional plans, including plans that serve all regions of the country.

Although an MA plan must still offer the same benefit package as offered under Medicare Parts A and B, or

its actuarial equivalent, there are additional requirements for some MA plans. A plan may impose higher co-payments for services received from non-network providers. A regional MA plan must offer a single deductible for both Part A and Part B benefits, which can be applied differently for in- and out-of-network services. The plan may waive the deductible for preventive services. Finally, a regional MA plan must offer catastrophic coverage, with different limits applying for out-of-pocket expenses for in- and out-of-network Part A and Part B benefits.

Someone enrolled in an MA plan that offers prescription drug coverage must obtain drug coverage through the plan; they may not enroll in a PDP. MSA enrollees and enrollees in MA private fee-for-service plans that do not provide qualified prescription drug coverage may enroll in a PDP. An MA plan may provide supplemental prescription drug coverage which does not count towards the out-of-pocket threshold. In addition, an MA plan may offer only supplemental coverage without offering a basic drug plan if it does not require an enrollee to pay a premium for that coverage.

Starting in 2010, the Secretary will designate six different areas of the country to participate in a six-year "comparative cost adjustment" demonstration project. Congress intends the demonstration, more commonly referred to as "premium support," to test the effect of competition between private plans and the traditional Medicare program. CMS will establish a competitive "benchmark" based on bids of private plans and the fee-for-service amount in each area chosen. Beneficiaries enrolling in an option with bids lower than the benchmark will receive 75% of the difference; those enrolling in an option with bids above the benchmark will have to pay the difference. Because MA plans will be paid substantially more than the cost of providing fee-for-service benefits to the average beneficiary, and because managed care plans tend to enroll healthier individuals, it is likely that the bids submitted by the MA plans will be lower than the fee-for-service amount. Projections indicate that Part B premiums may increase as much as 88% in some areas under premium support for beneficiaries who remain in traditional Medicare.

Cost Containment Resulting in New Definition of Medicare Insolvency:

In the guise of cost containment for the Medicare program, the Medicare Act creates a new definition of Medicare insolvency that may threaten Medicare's existing benefit structure. The law requires the annual issuance of federal reports that identify if and when more than 45% of Medicare's total costs are projected to come from general revenue. If reports two years in a row predict that this arbitrary insolvency point will be reached within six years, then the President must send recommendations to Congress for legislation to address the under-funding. The provision has the potential for creating unnecessary concerns about the security of Medicare that could lead to even more radical restructuring proposals.

It is important to note that, in creating both Medicare Part B and the new Part D drug benefit, Congress *intended* that they be financed primarily by general revenues, and, in fact, the Medicare statute does not limit financing from general revenues to 45% of total Medicare spending. Further, no other programs funded by general revenues are subjected to such an arbitrary cap on financing.

The 45% figure calls in to question the ability of Congress to use future income tax reforms that increase revenues to cover increased Medicare costs. As a result, Congress would only be able to address the crisis by cutting benefits or increasing cost sharing, reducing provider payments, or increasing the payroll tax contributions - a solution that falls more heavily upon lower-income individuals.

III. OTHER CHANGES

Changes to the Appeals Process:

The Medicare Act provides for the transfer of administrative law judges (ALJs) from the Social Security Administration to the Department of Health and Human Services (HHS) between July and October 1, 2005. SSA and HHS are to submit a report to Congress by April 1, 2004 explaining their plan for the transfer, including staffing and financial requirements. When transferred, the ALJs cannot be housed in and must be separate from CMS and its contractors, and the office of ALJs must report only to the Secretary of HHS.

The Medicare Act makes changes to appeal reforms that were made by BIPA 2000 but never implemented. The BIPA time frame for issuing redeterminations and reconsiderations is extended from 30 to 60 days. The Medicare Act modifies some of the requirements for Qualified Independent Contractors (QICs), which are entities established under BIPA to provide an independent level of review after a review by the fiscal intermediary but before the ALJ. Again, CMS has yet to contract with entities to serve as QICs or otherwise to establish the QIC level of review.

Starting in 2005, the jurisdictional amount for requesting an ALJ hearing or for requesting judicial review will be increased by the percentage increase in the medical care component of the consumer price index for urban consumers. The jurisdiction amount for requesting an ALJ hearing of a Part B claim was reduced by BIPA from $500 to $100 to bring it in line for the amount for non-hospital Part A claims. The Medicare Act now increases the amount again.

The Act also establishes two new appeals procedures. The first creates a process, effective for appeals filed on or after October 1, 2004, for expedited access to judicial review when the Departmental Appeals Board (DAB) lacks authority to decide a question of law or regulation relevant to the issue and there is no material issue of fact in dispute. The process applies to both claims for benefits and skilled nursing facility enforcement cases. A beneficiary or provider may file a request for expedited review at the same time or after filing a request for an ALJ hearing, and a three-member review entity (made up of ALJs and members of the DAB) must make a determination on the request within 60 days. If the request for expedited review is granted, or if the review entity fails to act within the time frame, then the beneficiary has 60 days to file in federal district court. If the decision is unfavorable, the beneficiary proceeds with the ALJ hearing and may not make another request for expedited review. The new process is effective for appeals filed on or after October 1, 2004

The Secretary is also supposed to establish, by June 2005, a limited prior determination process for physician services designated by the Secretary as eligible for review. Under the process a participating physician who has the consent of a beneficiary, or a beneficiary who has received an Advanced Beneficiary Notice (ABN), may request the appropriate Medicare contractor to determine, before services are provided, whether Medicare will pay for the services. A favorable decision is binding on the contractor, so that the beneficiary may receive the service and be assured of Medicare payment. If the contractor issues an unfavorable decision, the beneficiary may still choose to receive the service and have the claim submitted to Medicare. The beneficiary would then be able to appeal through the traditional appeals process any unfavorable decision after the claim has been submitted.

Medicare Secondary Payer Provisions:

The Medicare statute, 42 U.S.C. § 1395y(b)(2), previously precluded Medicare from paying for services to the extent that payment was made or could reasonably be expected to be made promptly (defined in regulations) under a worker's compensation law or plan, or under an automobile or liability insurance policy

or plan, including a self-insured plan, or under no fault insurance.

The Medicare Act modifies this section (1) to preclude Medicare payment if payment has been made or can reasonably be expected to be made promptly, (2) to give Medicare discretion to pay if a primary plan has not or cannot reasonably be expected to pay promptly (as defined by regulation), and (3) to condition payment on reimbursement to Medicare.

Further, the Act expands the definition of "primary plan" which has the obligation to pay first beyond a group health plan, large group health plan, workers' compensation plan, automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance. Now, an entity that engages in a business, trade, or profession is deemed to have a self-insured plan if it carries its own risk, whether by failure to get insurance or otherwise, in whole or in part.

The Act expands those who have an obligation to reimburse Medicare for conditional payments to include a primary plan *and an entity that receives payment from a primary plan*, such as the attorney who receives payment from the primary plan. Responsibility of a primary plan to make payment may be demonstrated by a judgment, a waiver, or release of payment included in a claim against the primary plan or the primary plan's "insuree". Reimbursement must be made before the expiration of the 60-day period beginning on the date notice of, *or information related to*, a primary plan's responsibility for payment is received, or else Medicare can impose interest. The Act also expands the parties against whom Medicare may recover payment to include any or all entities that are or were required or responsible to make payment under a primary plan.

These provisions are made effective as if included when the amended Medicare Secondary Payer provisions were enacted in the 1980's.

Health Savings Accounts:

The Medicare Act creates new Health Savings Accounts (HSAs) that allow certain individuals to put money into special accounts and withdraw the money, tax-free, at a future date for health care. Unlike the money in flexible savings accounts, the money in an HSA can be invested and does not have to be used in the year in which it is deposited. An employer may also contribute to an HSA, and the contributions are not included in gross income.

In order to be eligible to establish an HSA, the individual must be covered under a high deductible health plan and not be covered under any other kind of health plan, with the exception of accident, disability, dental care, vision care, or long-term care. A long-term care insurance policy *does not* qualify as a high deductible plan. Neither do plans covering only accidents, disability, dental, or vision.

An eligible individual can contribute the lesser of the annual deductible under his high deductible health plan, or $2,250 for an individual with self-only coverage or $4,500 for an individual with family coverage. The amounts are increased annually for inflation.

Demonstration Projects and Reports:

The Medicare Act creates a variety of demonstration projects and reports that may benefit certain beneficiaries who are able to participate in the programs. These include projects involving the deeming of certain beneficiaries to be "homebound" for purposes of eligibility for home health benefits, projects

covering medical services in adult day care as part of the home health benefits, and projects concerning quality standards for coordinated care for beneficiaries with certain chronic conditions.

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20 THINGS YOU MAY NOT KNOW ABOUT THE MEDICARE ACT OF 2003

— BUT SHOULD —

When the Medicare prescription drug coverage was proposed beneficiaries were told that they should expect a program that was as generous as the plan available to Congress. The program offered by the new law does not meet this standard. Unlike the new Medicare drug program, most members of Congress have a drug benefit that does not include a deductible in addition to the one in their health plan. Also unlike the Medicare plan, their insurance does not include the large "doughnut hole" gap in coverage for drugs, nor do members of Congress pay an additional premium for their drug coverage as Medicare beneficiaries will.

Did You Know That The Medicare Act of 2003:

1. Does not include the prescription drug benefit within the Medicare program itself. Instead, the Act requires people who choose the voluntary prescription drug benefit to select and enroll in a private plan to obtain prescription drug coverage.

2. Imposes a late penalty on people who don't enroll in a drug plan when they are first eligible, unless they have "creditable coverage." Creditable coverage includes coverage that is comparable to the new Medicare Part D prescription drug benefit such as coverage provided under Medicaid or an employer-sponsored health plan. The Act says that drug coverage obtained under a Medigap policy is not considered "comparable coverage". Drug coverage obtained under a Medigap H, I, or J policy may not be considered comparable coverage; someone with a Medigap H, I, or J policy who delays enrollment in a Medicare drug plan may have to pay the late penalty.

3. Does not establish a standard Part D premium amount. The $35 amount used in discussions is just an estimate of what the "average" premium *might* be. The actual premium will vary by plan and by geographic area.

4. Allows drug plans to vary the basic drug benefit (for example, the $250 deductible, 25% co-payment up to $2250) as long as the benefit package offered is the "actuarial equivalent" (meaning it is estimated to be the same value) as the basic benefit.

5. Allows each drug plan to decide independently which drugs to cover under its formulary.

6. Requires people to remain in the drug plan they choose for a year, but allows drug plans to change the

drugs they cover during the year.

7. Requires prescription drug plans to make available information about changes in the formulary but does not require the plan to actually provide the information directly to enrollees.

8. Requires beneficiaries to pay the full cost of prescriptions in what is known as "the doughnut hole" until the $3600 out-of-pocket spending cap is reached. The "doughnut hole" is the complete gap in coverage between $2,250 and $5,100. The $3600 out-of-pocket requirement includes the deductible and co-payments, but only when paid for drugs on the plan's formulary.

9. Does not include the price of non-formulary prescriptions when calculating the $3600 out-of-pocket spending cap. Co-payments, deductibles, and other costs paid for by a retiree health plan also are not counted. This means that most people will spend more than $3600 out-of-pocket before reaching the catastrophic coverage.

10. Prohibits, as of January 1, 2006, the sale of Medigap policies H, I, and J, which provide prescription drug benefits, except to people who already have those policies on that date.

11. Does not allow Medigap policies to pay for the prescription drug deductible and co-insurance or for drug coverage in the "doughnut hole."

12. Does not allow the Secretary of the Department of Health and Human Services (HHS) to negotiate lower prescription drug prices on behalf of the nearly 41 million Medicare beneficiaries.

13. Forces people with Medicare and full Medicaid coverage (the dually eligible) into a Medicare drug benefit by precluding Medicaid from paying for prescriptions for people who are eligible for the drug benefit. Medicaid may not pay for drugs that are covered under Medicare Part D but that are not on a plan's formulary.

14. Increases the Part B deductible for the first time since 1991. Currently $100, it will increase annually beginning in 2005.

15. Increases the Part B premium based on income, for the first time ever. (Effective 2007.)

16. Provides coverage for an initial physical exam (but not related lab work.), *only* for people who first enroll in Part B after January 1, 2005. Current Medicare beneficiaries enrolled in Part B and those who become entitled to Part A after that date but never enroll in Part B do not receive this benefit.

17. Increases, rather than decreases, the time for processing a Medicare appeal by giving Medicare contractors twice as much time to review appeals at the contractor level.

18. Makes it harder to obtain a hearing for Medicare denials by increasing the dollar amounts which must be at issue in order to obtain an Administrative Law Judge hearing and to appeal to federal court.

19. Changes the name of Medicare Part C, which governs Medicare managed care plans, from Medicare+Choice (M+C) to Medicare Advantage (MA).

20. Changes the name of the entities that process claims from fiscal intermediaries (for Part A claims) and carriers (for Part B claims) to Medicare Administrative Contractors.

TIME-LINE FOR IMPLEMENTATION OF CERTAIN PROVISIONS OF

THE MEDICARE REFORM ACT OF 2003

December 8, 2003

QI 1 program, which provides assistance with Medicare Part B premium to low-income individuals, extended until September 30, 2004.

Moratorium on caps on the amount Medicare will pay for outpatient therapy services re-instated and continued through December 31, 2005.

January 1, 2004

Effective date of Medicare Part B coverage of intravenous immune globulin for the treatment in the home of primary immune deficiency diseases where medically necessary.

March 2004

Increased payments under Medicare Part C to Medicare managed care plans may result in some HMOs revising benefits and co-payments.

May 2004

Marketing for and enrollment in prescription drug discount cards begins.

June 2004

Prescription drug discount cards become effective. Discount card program terminates on December 31, 2005. However, enrollees may continue using their cards through a "transition period" which ends either when they enroll in a Medicare prescription drug plan under Medicare Part D or on May 15, 2006, the end of the initial enrollment period for Part D.

October 1, 2004

A new expedited appeals process for certain claims filed on or after this date is supposed to be in place. The relevant claims are those for which the Departmental Appeals Board lacks authority to decide a question of law or regulation relevant to the issue and in which there is no material issue of fact in dispute.

January 1, 2005

Part B deductible increases from $100 to $110. The deductible will increase yearly by the annual percentage increase in the monthly actuarial value of benefits payable under Part B.

Coverage begins for an initial physical exam, but not lab tests, performed within 6 months of a beneficiary enrolling in Part B. This is not a new benefit for those already enrolled.

Coverage begins for cardiovascular screening blood tests such as a cholesterol test, once every two years at most.

Coverage begins for diabetes screening via a fasting plasma glucose test for individuals at high risk for diabetes.

Increase begins in the jurisdiction amount for requesting an administrative law judge hearing or for requesting judicial review of a denied claim. The amount will be increased by the percentage increase in the medical care component of the consumer price index for urban consumers.

June 1, 2005

The date by which the Department of Health and Human Services (DHHS) is supposed to establish a limited prior determination process for physician services designated by the Secretary of DHHS as eligible for review.

October 1, 2005

The latest date by which the Social Security Administration (SSA) and DHHS are supposed to effectuate the transfer of administrative law judges from SSA to DHHS. *The transfer may occur as early as July 1, 2005*.

Name change effective for entities that review Medicare claims. Fiscal intermediaries and carriers become known as Medicare Administrative Contractors (MACs).

November 15, 2005

Start of initial enrollment period in Medicare prescription drug plans under the new Part D. The initial enrollment period lasts for 6 months and ends on *May 15, 2006*.

January 1, 2006

Effective date of Medicare prescription drug coverage under Medicare Part D.

No new Medigap plans H, I, and J, which provide prescription drug coverage, may be sold.

Two new Medigap polices are expected to be available in 2006. These policies will provide less coverage for Medicare co-payments and deductibles but will include limitations on out-of-pocket expenses.

Completion of name change phase-in for Medicare Part C from Medicare+Choice to Medicare Advantage.

Effective date for new regional PPOs, should private insurance companies choose to offer them, under the Medicare Advantage program.

January 2007

Individuals with incomes over $80,000 per year and couples with incomes over $160,000 per year will have to pay a greater share of the Part B premium.

2010

Start of the premium support "comparative cost adjustment" demonstration project, in which traditional Medicare will have to compete with managed care plans in 6 different parts of the country.

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