



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

Did You Know That The Medicare Act of 2003:

1. Does not include the prescription drug benefit in Medicare. 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 and that is provided under Medicaid or under an employer-sponsored health plan. The Act says that drug coverage obtained under a Medigap policy is not considered comparable coverage; someone with a Medigap drug policy who delays enrollment in a Medicare drug plan will have to pay the late penalty.
3. Does not establish a standard 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, which are also counted 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 had those policies on that date.
11. Precludes Medigap policies from paying for the prescription drug deductible and co-insurance and from paying 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 (currently \$100) on a yearly basis. The deductible has been \$100 since 1991.
15. Increases the Part B premium based on income, for the first time ever.
16. Provides an initial physical exam, *only* for people who first enroll in Part B after January 1, 2005. Current Medicare beneficiaries 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. Increases, on a yearly basis, the dollar value of denied claims people can appeal to an Administrative Law Judge and to federal district 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 contractors.