

CENTER NEWS

Advancing Fair Access to Medicare and Health Care for 21 Years

CENTER FOR MEDICARE ADVOCACY, INC.

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MEDICARE PREMIUMS & DEDUCTIBLES FOR 2008

On October 1, 2007 the Centers for Medicare & Medicaid Services (CMS) announced the Medicare cost-sharing, premiums, and deductibles for 2008. The new rates reflect the ever increasing out-of-pocket costs for Medicare beneficiaries as a result, in large part, of the high cost of subsidizing private Medicare plans. This is a tragic irony as the rate increases will no doubt encourage those who call for an end to the traditional Medicare program – despite the fact that traditional Medicare is a far less expensive and more effective approach to providing health care coverage than Medicare private plans. The 2008 Medicare cost-sharing rates are as follows:

Part A

Hospital

Deductible: \$1,024 / Benefit Period

Coinsurance:

Days 0-60: \$0

Days 61-90: \$256 / Day

Days 91-150: \$512 / Day

Skilled Nursing Facility Coinsurance

Days 0-20: \$0

Days 21-100: \$128 / Day

Part A Premium (For voluntary enrollees *only*)

Individuals with 30-39 quarters of Social Security coverage: \$233 / Month

Individual with 29 or fewer quarters of Social Security coverage: \$423 / Month

Part B

Deductible: \$135 / Year

Standard Premium: \$96.40 / Month

Income-Related Premium: \$122.20 / Month

(Individuals with income > \$82,000 and ≤ to \$102,000

Couples with income > \$164,000 and ≤ to \$204,000)

REAL MEDICARE REFORM: CLOSE, BUT NO CIGAR

Health care advocates experienced a moment of victory in August after the House of Representatives passed the comprehensive CHAMP Act. As the Center for Medicare Advocacy reported, CHAMP redirected federal money from private insurance companies to promote access to health care for children, people with disabilities and older people. Optimism as a result of the summer victory was diminished in the fall, however, when the Senate failed to include Medicare provisions in its version of the bill to reauthorize the State Children's Health Insurance Program (SCHIP), the President vetoed the

MEDICARE REFORM (Continued from Page 1)

SCHIP bill that did pass, and threatened to veto any Medicare bill that reduced the Medicare Advantage subsidies.

A majority in the House, and many members of the Senate, continued to fight for SCHIP expansion to protect the 9 million uninsured children in America and to pass a Medicare bill that properly pays physicians who treat Medicare patients, cuts overpayments to private plans, and works to ensure the future of an affordable, comprehensive Medicare program.

Since January 2007 numerous bills have been introduced in the Senate that would make significant improvements for beneficiaries in the Medicare program. These bills could, and should, be part of any Medicare legislation. We summarize some of the important legislative ideas here:

- **Protect and preserve the integrity of the Medicare program:** In 2003 Congress passed artificial cost containment rules for Medicare intended more to do away with Medicare than to address future issues of Medicare financing. One of these rules creates an arbitrary trigger to examine Medicare payment, benefits and cost-sharing when 45% of Medicare financing is expected to come from general revenues in a set future date – even though Medicare Part B and Part D were designed to be financed primarily by general revenues. Another rule, to take effect in 2010, the “comparative cost demonstration,” could result in a large increase in the Part B premium for beneficiaries who live in communities affected by the demonstration. The *Preserving Medicare for All Act* (S. 137), introduced by Senator Cardin (D. MD), protects the integrity of Medicare by repealing these artificial rules.
- **Reduce Medicare cost-sharing for mental health services:** Beneficiaries now pay 50% coinsurance for most outpatient mental health services instead of the 20% coinsurance for most other outpatient services. *The Mental Health Co-payment Equity Act of 2007* (S. 1715), introduced by Senator Snowe (R. Maine) and Senator Kerry (D. MA), would gradually reduce the cost-sharing so that there is parity in cost-sharing for mental health services.
- **Enhance access to preventive care:** *The Medicare Preventive Services Act of 2007* (S. 2115), introduced by Senator Cardin (D. MD), would eliminate all cost-sharing for preventive benefits, allow the Secretary of health and Human Services to authorize Medicare coverage for new preventive services that have been proven efficacious without seeking an amendment to the Medicare statute, and would extend the “Welcome to Medicare” physical to the first year of Part B enrollment.
- **Improve access to programs for beneficiaries with low or limited incomes:** Senator Bingaman (D. NM) and Senator Smith (R. OR) have introduced a number of bills (S. 1102, 1103, 1107, 1108, 2101) that would remove some of the barriers to access to programs that provide assistance with Medicare Part B premiums and Part D premiums and/or cost-sharing. Among other provisions, these bills would
 - Make permanent and expand the income level for the Qualified Individual (QI) program, which pays Part B premiums;
 - Increase the asset limit for the Part D low-income subsidy (LIS) and for all Medicare Savings Programs (MSPs);

- eliminate permanently the Part D late enrollment penalty for beneficiaries who qualify for LIS;
 - Allow drug costs paid for by AIDS Drug Assistance Programs (ADAP) and some other programs to count towards the Part D out-of-pocket limit so that more people could qualify for reduced cost sharing for catastrophic expenses;
 - Eliminate Part D cost-sharing for individuals with Medicare and full Medicaid who are receiving care through home and community-based waiver programs;
 - Increase funding to State Health Insurance Assistance Programs (SHIPS).
- **Improve Part D prescription drug coverage:** Several bills were introduced to address problems with Medicare Part D. For example, the *Medicare Access to Critical Medications Act of 2007* (S. 1887), introduced by Senator Smith (R. OR) and Senator Kerry (D. MA), would codify current policy that requires plans to cover substantially all drugs in six protected classes of drugs.

The *Preserving Medicare for All Act of 2007* (S. 137) would, among other provisions, create a national drug plan that is part of Medicare, allow Part D plans to cover benzodiazepines, a class of drugs commonly used to treat mental illness, and allow Medicare to negotiate lower prices for drugs.

- **Increase consumer protections for beneficiaries enrolled in prescription drug plans and in Medicare Advantage plans:** Senator Kohl (D. WI), Senator Dorgan (D.ND), and Senator Wyden (D.OR) introduced the *Accountability and Transparency in Medicare Marketing Act of 2007* (S. 1883) to provide for standardized marketing requirements for prescription drug plans and Medicare Advantage plans.

Congress has an opportunity to continue the work it has done already, through numerous hearings and through the introduction of these and other bills, to truly improve the long-term viability of a cost-effective Medicare program. Hopefully the new year will see enactment of meaningful Medicare reform that will enhance the program and protect the people for whom the program was designed – older people and people with disabilities who rely on Medicare in order to obtain health care.

To Our Readers:

This is a combined Fall 2007/Winter 2008 edition of the *Center News*.
Printing a combined edition was necessitated by a delay and reduction in some of our funding.

As always, your interest and support for our work is greatly appreciated.

If you have not already done so, please make a tax deductible donation to the
Center for Medicare Advocacy, Inc.

On-line at www.medicareadvocacy.org , or send a check to:
Center for Medicare Advocacy, Inc. PO Box 350, Willimantic, CT 06226.

Thank you!

2008 MEDICARE RATES (Continued from Page 1)

Part D Standard Plan Cost-Sharing

Deductible: \$275.00 / Year
Initial Coverage Limit: \$2,510.00 / Year
Out-of-pocket Threshold: \$4,050.00 / Year
Total Covered Part D Drugs to Get to Catastrophic Limit: \$5,726.25 / Year
Catastrophic cost-sharing: Generic/ Preferred Drug: \$2.25 / Rx
Other: Brand, Non-preferred: \$5.60 / Rx

Low-Income Subsidy Co-Payments (LIS)

- Full Benefit Dual Eligibles w/ incomes < 100% Federal Poverty Level
- Generic/Preferred Drugs: \$1.05 / Rx
- Other - Brand, Non-preferred: \$3.10 / Rx
- Above Catastrophic Limit: \$0.00

Full Benefit Duals w/ Incomes >100% Federal Poverty Level & Other Full-Subsidy Eligible Beneficiaries

- Generic/preferred drugs: \$2.25 / Rx
- Other - Brand, Non-preferred: \$5.60 / Rx
- Above Catastrophic Limit: \$0.00

Partial Subsidy Eligible Beneficiaries

- Deductible: \$56.00 / Year
- Co-insurance to Catastrophic Limit: 15% / Rx
- Above Catastrophic limit - Generics: \$2.25 / Rx
- Above catastrophic limit Other - Brand, Non-preferred: \$5.60 / Rx

Note: CMS eliminated the 2008 Part D late enrollment penalty for beneficiaries who qualify for the Low-Income Subsidy (LIS) and who enroll in a drug plan on or before December 31, 2008.

QUALIFIED INDIVIDUAL (QI) PROGRAM EXTENDED

Congress continued the Qualified Individual (QI) program through June 30, 2008. The President is expected to sign the legislation. This will continue payment of Part B premiums for the approximately 1.5 million people who receive QI benefits – at least for a while. The Center for Medicare Advocacy worked with many other organizations for the passage of legislation, before the end of the year, which would make the QI program permanent, rather than subject to periodic sunset provisions. The QI benefit is doubly valuable to those who are eligible, as it pays the Part B premium (\$96.40/month for most people in 2008) and also entitles the beneficiary to the full Part D low income subsidy. Hopefully the next Congress will ensure the future of this program beyond June 30th.

CENTER EDITORIAL

QUACKS LIKE A DUCK: SUBSIDIES TO PRIVATE MEDICARE PLANS

Apparently not all cost overruns are created equal. Case in point: the well-documented, \$150 billion subsidies being paid to private Medicare plans – about 12% more than would be due for enrollees in the regular Medicare program. The Senate failed to follow the lead of the House of Representatives to protect the integrity and stability of the Medicare program by cutting these subsidies. The Administration threatened to veto any bill that even trimmed the subsidies, under the guise of being against legislation that reduces choice and access for Medicare beneficiaries.

Thus the subsidies continue for another year, notwithstanding repeated studies and little debate about their wastefulness. (See, "Two Insurers Increase Bet on Medicare," Milt Freudenheim, *NY Times*, 12/5/2007.) Even with the subsidies, many private Medicare plans are reducing coverage and adding to patient cost-sharing. Meanwhile, all beneficiaries and taxpayers bear the financial burden of maintaining the extravagant overpayments. Unless action is taken, private Medicare plans will collect a total of \$150 billion in subsidies, while doctors who care for Medicare patients face a 10% cut in payments.

The private plan overpayments affect all Medicare beneficiaries. They lead to increases in Part B premiums and encourage plan proliferation and marketing abuses by companies looking to benefit from the robust Medicare payments. These overpayments affect all Americans by weakening the financial stability of the Medicare program and by increasing federal expenditures. Even a recent study issued by a for-profit insurance industry group shows that, *at best*, private Medicare plans spend 300-400% more on administration than traditional Medicare.¹

The lavish subsidies to private plans continue at the same time that we are repeatedly warned, in solemn tones, that "we just can't afford Medicare" for our ever-increasing aging population. The Administration rails at fraud, waste and abuse throughout the federal government, yet the President and a powerful minority in the Senate were able to block action to reduce the billions of dollars in overpayments to corporate Medicare. As a result, taxpayers, most people with Medicare, and doctors are losers. Private corporations win – big time.

Some claim that the 20% of Medicare beneficiaries enrolled in private plans will lose benefits and oversight if payments to Medicare Advantage plans are cut. But many private plans are cutting benefits and passing along additional costs to Medicare beneficiaries anyway – even though they continue to be paid far more than traditional Medicare. Further, there is no evidence that private Medicare plans provide more care coordination than is available in traditional Medicare. In fact, beneficiaries who choose an MA plan are likely to find that it limits the doctors and other healthcare providers they can use. The traditional program allows them freedom of choice among almost all providers - that's the kind of choice that matters to people.

Private plans do not provide the flexibility or stability of the traditional Medicare program, which covers 80% of all beneficiaries, and they should not be paid more than traditional Medicare. The overpayments to private Medicare plans look, smell, and act like a boondoggle. As Chico Marx said in *Duck Soup*, "Who you gonna believe, me or your own eyes?"

¹ Council for Affordable health Insurance, *Medicare's Hidden Administrative Costs: A Comparison of Medicare and the Private Sector* (Based in Part on a Technical Paper by Mark Litow of Milliman, Inc.), Merrill Matthews, Ph.D. January 10, 2006.



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