# The Medicare Improvements for Patients & Providers Act of 2008

On July 15, 2008 the Medicare Improvements for Patients & Providers Act of 2008 was passed in to law. In reviewing recent information published pertaining to this new law, we find the law does in fact contain many improvements for the Medicare beneficiary. While some aspects of the law will have an impact on the beneficiary immediately, others will be in the coming years. Below is a general summary of primary provisions of the new law:

**Qualifying Individual Program (QI)** – The QI program under the Medicare Savings Programs (MSPs) was extended through December 31, 2009 (plus a raise in the funding cap).

**Late Enrollment Penalty**: Beginning January, 2009, the law eliminates the Part D LEP for LIS eligible individuals. Note the 2008 LEP had already been eliminated for LIS eligible individuals back in October 2007 by CMS.

**Medicare Savings Programs (MSP)** – Effective 2010, the law increases the asset test for MSP applicants to the LIS level for full subsidy and will increase yearly to match the LIS asset limits.

**LIS Income & Resource Definitions Changes**: For LIS applications filed on or after January 1, 2010, life insurance (including the cash surrender value) and in-kind support and maintenance example – assistance provided by a family member or church) are exempt resources and income in LIS determinations.

**LIS Determinations**: Effective immediately, a beneficiary will have the right to a federal court review of a denial for LIS.

**Medicare Savings Programs (MSP) Applications**: Effective January 1, 2010 the MSP application must be made available in at least 10 languages (other than English) that are most often used by Medicare beneficiaries and made available to states. Further in order to be able to promote a beneficiary's understanding of the MSP and LIS programs thus increasing participation, the law is requiring employees of SSA who are involved in receiving applications to be trained in all programs and to assist in completion of applications for these programs.

**Dual Eligible Individuals/SNPs**: Imposes limitations in cost sharing for dual eligible (Medicare & Medicaid) who are enrolled in an SNP (Special Needs Plan) so that it may not exceed what their cost sharing would be under Medicaid Program.

**Therapy Caps**: the Extension of exceptions process for therapy caps was extended until December 31, 2009.

**DMEPOS Competitive Bidding Program** – Implementation of this program was delayed 18 months (retroactive to July 1, 2008). Note: CMS announced that all Medicare beneficiaries in the CBAs will receive a letter within the next 2 weeks explaining the program delay and their options. Example of letter to be mailed can be found on the last page of this publication.

**Preventive Services**: The "Welcome to Medicare" exam was improved by waiving the Part B deductible and extending eligibility from 6 months to 1 year. Effective for services provided on or after January 1, 2009.

**Mental Health Services**: Over the next 6 years, the Medicare beneficiary coinsurance expense will be reduced from 50% to 20% for outpatient mental health treatment. This will place the coinsurance rate at same level as other outpatient Medicare treatment.

**Chronic Obstructive Pulmonary Disease & Other Conditions**: Effective January 1, 2010 will include coverage of intensive cardiac rehabilitation programs. Also, effective January 1, 2009 the law repeals transfer of ownership of oxygen equipment.

**Medigap**: Modifications to NAIC Medicare Supplement Model #651 are to be completed and adopted by the NAIC no later than October 31, 2008. Each state then has 1 year from date the NAIC adopts revised NAIC Model law and regulation to adopt for their state. Some of the proposed modifications are: elimination of several plans; create two new plans; make some changes to Medigap benefits; requiring carriers to offer either plan C or F in addition to the existing requirement that they must offer Plan A. **Please note these changes will not be immediate**.

**Medicare Advantage and PDPs**: There are a number of changes relative to Medicare Advantage and PDPs that will be coming up some immediately while others over the next couple of years. Please see the following for some of the key items:

- Requires plans to abide by state agent appointment laws, use only licensed agents and report agent terminations including reason for termination to state. Applies to plan years beginning on or after January 1, 2009

- Plans are prohibited from providing meals of any sort, regardless of value, to prospective enrollees at promotional and sales activities; prohibited from cross-selling of non-health related products during a MA/PDP sales or marketing presentation; prohibits "unsolicited direct contacts" including door-to-door sales and cold calls without the prospective enrollee initiating contact; and prohibits sales and marketing for enrollments in health care settings where healthcare is delivered (pharmacies, physician offices, etc.*) and at educational events. These prohibitions apply to plan years beginning on or after January 1, 2009.

- Scope of marketing appointments – Limits the marketing appointments to the scope agreed to by the beneficiary in advance. Effective no later than November 15, 2008.

- Prohibits co-branding network providers on plan membership and marketing materials; limits the offering of gifts and promotional items to a nominal value (as determined by HHS). Effective no later than November 15, 2008.

- Requires the Secretary of HHS to establish compensation guidelines to ensure the compensation incentives to enroll a beneficiary in a MA plan is intended to best meet beneficiary needs. Requires training and testing of agents and brokers. To be effective no later than November 15, 2008.

- Plan Names - For plan years beginning on or after January 1, 2010, a MA organization must ensure that the name of each MA plan offered by the organization includes the plan type of the plan (using standard terminology developed by the Secretary of HHS). Will also apply to PDPs.

- PFFS change – Beginning with plan year 2011, requires PFFS plans in counties where there are two (2) HMOs or PPOs to form contracted networks of providers. Also, beginning with plan year 2010, PFFS plans (and MSAs) are to have the same quality improvement programs as local PPOs.

- PDPs – Effective January 1, 2013 the new law permits coverage under Part D of barbiturates (in treatment of certain conditions, epilepsy, cancer, or chronic mental health disorder) and benzodiazepines.