



Timeline for Key Medicare Changes under H.R. 6331

On July 15, 2008, the U.S. House and Senate voted to override President Bush's veto of H.R. 6331, the Medicare Improvements for Patients and Providers Act of 2008. This law contains important changes to the Medicare program. While the main focus of the bill was to assure that scheduled cuts to physician payments were blocked, it also contained several important protections for beneficiaries.

A section by section description of the law can be found at:

<http://waysandmeans.house.gov/media/pdf/110/sbs.pdf>.

The text of the legislation can be found at:

<http://waysandmeans.house.gov/media/pdf/110/6631.pdf>.

If you need further information about a particular provision of the bill, the text will provide more information. However, the text often references other parts of the Social Security Act and it may be necessary to view those other parts as well. Contact John Coburn of Health & Disability Advocates if you need assistance in finding those referenced provisions or have other questions.

Some provisions of this new law put into statute what may already be in CMS guidance or final or proposed rules and regulations. While such provisions may not, in effect, change what is currently required, allowed or prohibited, placing such provisions into the actual text of a statute assures stability. CMS Guidance is changed by CMS by simply issuing new guidance. CMS Regulations are changed by notice and publication of new rules. Once something is in an enacted statute, only another Act of Congress can change it.

All of the provisions of the bill are not effective immediately. Set out below, in order of effective date, are brief descriptions of provisions particularly relevant to Medicare beneficiaries and those who counsel them.

Effective Immediately or 2008

Section 103: This provision codifies certain prohibitions and limitations on sales activities of Medicare Advantage plans and Part D drug plans. Some of these prohibitions begin no later November 15, 2008, including limiting the marketing appointments to a scope agreed upon in advance, prohibiting co-branding network providers on plan membership and marketing materials, and directing the Secretary to limit offering of gifts and promotional items. In addition, beginning November 15, 2008, plans are prohibited from providing compensation that does not follow guidelines set by the Secretary to assure that agents and broker are incentivized to enroll in plans that best meet what the beneficiary needs.

Section 111: This provision extends the QI program through December 31, 2009 and increases the funding. This program technically “expired” for a period of time and some states did send termination notices.

Section 117: Previous law did not specifically require that LIS determinations be subject to judicial review, but Social Security regulations did provide for this. This provision codifies a beneficiary’s right to federal court review of an eligibility decision for LIS.

Section 119: This section allocates money to State Health Insurance Assistance Programs and Areas Agencies on Aging to help enroll low-income seniors in assistance programs and all seniors navigate the Medicare Program. Funds are allocated for FY 2009.

Section 131: Physician payment cuts were scheduled to begin July 1, 2008. Although technically in effect when this bill passed, CMS was holding payment to see if Congress would act. This provision blocks those cuts and provides a 1.1% update for 2009.

Section 154: A pilot program called the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Acquisition Program (CAP) began July 1, 2008 at 10 geographic locations. This section imposes an 18-month delay to Round 1 of this program.

Effective 2009

Section 103: See above for further description. Certain sales activity prohibitions and limitations begin with the new plan year 2009 for MA Plans and PDPs. Such prohibitions include providing meals at promotional or sales activities, cross-selling of non-health related products during MA/PDP presentations, unsolicited direct contacts and sales/marketing in health care settings where healthcare is delivered. In addition, plans must follow state agent appointment laws affecting agents and brokers and otherwise cooperate with the states.

Section 114: This provision eliminates the late enrollment penalty for those who are eligible for the LIS Program. This is currently in guidance for 2008. Beginning in 2009, it would be permanent.

Effective 2010

Section 102: Currently, Medicare outpatient mental health services require beneficiaries to pay a 50% co-payment under Part B. Other physician services under Part B require only a 20% co-payment. A phased reduction in this co-payment for outpatient mental health services begins in 2010. In the actual statute, the current co-payment amount is not described as "50%". Rather, it defines what counts as incurred costs in such a way that the result is a 50% co-payment. So, the current statute counts incurred costs at 62.5% and this results in a 50% copayment for beneficiaries. In 2010, instead of incurred costs counting at 62.5% as they do now, they are counted at 68.75%. Once the definition of incurred costs reaches 100%, there is parity.

Section 112: Currently, the Medicare Savings Programs (QMB, SLIB, QI-1) have countable resource limits of \$4000 for an individual and \$6000 for a couple. This provision increases the amount of allowable resources for applicants to these programs so that it is the same as the resource limit for the full low-income subsidy individuals in 2010. The full low-income subsidy program has higher resource limits that increase based on a formula every year. Therefore, this change should result in an enrollment increase into these Programs, which can provide much needed assistance in Medicare cost sharing.

Section 113: Beginning January 1, 2010, SSA shall have in place a system for electronically transmitting information from an LIS application to the appropriate state agency that accepts Medicare Savings Program applications. Transmittal will only

occur with consent of the beneficiary. The information will be used to complete an application for the Medicare Savings Programs.

Section 115: Under the current Social Security statute, states are allowed to collect from the estates of deceased individuals any items or services under a state Medicaid plan that were provided to the individual when he or she was 55 or older. This Section amends the statute to eliminate that authority to collect from Medicare cost-sharing (the Medicare Savings Programs) beginning in 2010.

Section 116: With respect to applications filed on or after January 1, 2010, the value of a life insurance policy and in-kind support and maintenance will not be considered as income or resources for LIS determinations.

Section 118: This provision requires the Secretary provide the application for the Medicare Savings Program in the 10 languages (other than English) most commonly used by applicants for Medicare hospital insurance to states and the Social Security Administration. Such applications must be provided by January 1, 2010.

Section 176: Beginning with the 2010 plan year, the Secretary is required to identify categories of drugs and require that all drugs in those categories that are Part D covered drugs be included on all plan formularies. Such classes must meet specific criteria. It is generally expected that the current 6 protected classes would meet this criteria. The Secretary is also allowed to establish exceptions to this requirement for particular drugs within the class, including allowance for benefits management tools. However, any of these exceptions must meet particular criteria and can only be allowed after notice and comment.

Section 187: A report is due no later than two years of the date of enactment (July 15, 2010) that will describe the extent to which providers and plans are complying with Title VI prohibition against national origin discrimination affecting limited English proficient persons and the Office of Minority Health's Culturally and Linguistically Appropriate Services (CLAS) Standards. This report shall also make recommendation on improving compliance and enforcement of CLAS Standards.

Effective 2011

Section 187: Not more than one year after the release of the CLAS report on implement changes responsive to any deficiencies identified in the report.

Section 102: Incurred costs for outpatient mental health services continue at 68.75% in 2011 (same as 2010).

Effective 2012

Section 102: Incurred costs for outpatient mental health services increase to 75% in 2012, thereby decreasing the co-payment for beneficiaries even more than in 2010 and 2011.

Effective 2013

Section 102: Incurred costs for outpatient mental health services increase to 81.25% in 2013, thereby decreasing the co-payment for beneficiaries even more than in 2010, 2011, and 2012.

Section 175: Under the original statute, barbiturates and benzodiazepines were defined as Medicare Part D excluded drugs. However, as an excluded drug, state Medicaid agency did have the option to provide these drugs to Medicaid beneficiaries and receive the federal cost-sharing match. Beginning in 2013, barbiturates for certain conditions and benzodiazepines will be allowed on Medicare Part D formularies as Medicare Part D covered drugs. The certain conditions for covering barbiturates are epilepsy, cancer, and chronic mental health disorders.

Effective 2014

Section 102: Parity for the co-payment for outpatient mental health services is achieved in 2014. The co-payment is now the 20% required for other medical care.