Issue BRIEF

October 2008

Congress Delivers Help to People with Medicare:
An Overview of the Medicare Improvements for Patients and Providers Act of 2008

On July 15, 2008, Congress overrode President Bush's veto and enacted the *Medicare Improvements for Patients and Providers Act of 2008* (MIPPA). This law is perhaps best known for blocking scheduled cuts in Medicare's payments to doctors. What is less understood is that MIPPA makes other important and positive changes to Medicare. This paper provides an overview of these changes in three key areas: 1) improvements to Medicare benefits, especially for low-income beneficiaries; 2) new policies to reduce racial and ethnic disparities among people with Medicare; and 3) reining in rapidly-growing and inefficient private Medicare Advantage plans.

MIPPA is a complicated piece of legislation, running over 275 pages. Not all provisions are discussed here. In the coming months, we will provide further analysis of key MIPPA provisions. We will particularly focus on areas where advocates can work to ensure that the new policies are implemented effectively at the state and federal level.

New Benefits

■ Improvements to the Medicare Savings Programs

The Medicare Savings Programs (MSPs) are a family of three programs that provide assistance directly to low-income seniors and people with disabilities who rely on Medicare. (See box for a description of each program.)

- **Asset Limits for Medicare Savings Programs Increase Effective, 2010**
  Prior to MIPPA's enactment, the federal asset limits for Medicare Savings Programs eligibility had been frozen since the programs began in the 1980s. The asset limits were stuck at $4,000 for an individual and $6,000 for a couple, and were not indexed for inflation. States have the flexibility under Medicaid to use more generous asset rules, and several states have done so. However, most states have not gone beyond the very low federal minimum.

  Under MIPPA, the federal asset limits for Medicare Savings Plans will be increased to the same level as the full Part D low-income subsidy and will be indexed to inflation thereafter. This change takes effect January 1, 2010. Although the actual Part D asset level for 2010 will not be announced until late 2009, the 2008 limit for the full subsidy is $7,790 for an individual and $12,440 for a couple.

FamiliesUSA
The Voice for Health Care Consumers

What Are the Medicare Savings Programs?

Medicare Savings Programs are a family of three programs that provide assistance directly to low-income Medicare beneficiaries. For those who qualify, these programs provide direct financial help, offering them valuable relief from health care costs. The programs are: 1) Qualified Medicare Beneficiary (QMB); 2) Specified Low-Income Medicare Beneficiary (SLMB); and 3) Qualified Individual (QI). All three programs cover the cost of the Medicare Part B premium, which is currently $96.50/month. The QMB program also covers all other Medicare cost-sharing, including the Part A hospital deductible (currently $1,024) and Part B coinsurance (typically 20 percent for most doctor visits). Anyone who is enrolled in any Medicare Savings Program is also automatically qualified for the Part D low-income subsidy. Unfortunately, fewer than a third of those eligible are enrolled and receiving assistance.[1]

All three Medicare Savings Programs are administered through state Medicaid agencies as part of the Medicaid program. QMB and SLMB are jointly funded by states and the federal government. QI is entirely federally funded. Like other aspects of Medicaid, states have considerable flexibility in setting income and asset eligibility rules for all three Medicare Savings Plans, though many have stuck with the basic minimum federal eligibility rules. Table 1 provides a summary of the three programs.

Table 1: Medicare Savings Programs

Program	Benefits Covered	Income Limit as Percent of Poverty (amount in 2008 dollars)
Qualified Medicare Beneficiary (QMB)	Part B Premium ($96.50/month); Part A & B deductibles; Part A & B co-insurance*; automatic enrollment in Part D low-income subsidy	Up to 100% ($10,400/individual)
Specified Low-Income Medicare Beneficiary (SLMB)	Part B premium ($96.50/month); automatic enrollment in Part D low-income subsidy	100%-120% ($10-400-$12,480/individual)
Qualified Individual (QI)	Part B premium ($96.50/month); automatic enrollment in Part D low-income subsidy	120%-135% ($12,480 - $14,040/individual)

* The Part A hospital deductible is $1,024 in 2008. Standard Medicare coinsurance for outpatient care under Part B is 20 percent.

In addition to allowing more seniors and people with disabilities to qualify for their state's Medicare Savings Plans, this change should simplify the relationship between Medicare Savings Plans and the Part D low-income subsidy. Federal asset limits will be the same for all programs for beneficiaries with incomes up to 135 percent of the federal poverty level.

- **QI Reauthorized through December 2009**
  The QI program expired on June 30, 2008. MIPPA extends the QI program until December 31, 2009.

- **Estate Recovery for Medicare Savings Programs Eliminated, Effective January 2010**
  Prior to MIPPA, state Medicaid programs could pursue reimbursement from the estate of deceased Medicare beneficiaries. The amount recovered was equal to the state's contribution to benefits received under the QMB or SLMB programs (as well as full Medicaid) while the beneficiary was alive. Few states actually pursued recovery from the estates of QMB or SLMB beneficiaries because the amount of state funds in question was relatively minor. However, the threat of estate recovery deters eligible beneficiaries from applying for the programs.

  Under MIPPA, states will no longer be able to pursue estate recovery for benefits provided under QMB or SLMB. This change should encourage more eligible people to apply for these programs.

- **Better Coordinated Outreach with Social Security by 2010**
  Currently, low-income beneficiaries who enroll in the Part D low-income subsidy through the Social Security Administration are not screened for eligibility for Medicare Savings Programs. As a result, there may be many low-income beneficiaries receiving the low-income subsidy who are eligible for, but not enrolled in, a Medicare Savings Program to help with other Medicare costs.

  MIPPA takes several steps to address this problem. Starting in 2010, Social Security will transmit data about low-income subsidy applicants to states. States will be required to act on the data to determine if the applicant is also eligible for a Medicare Savings Program. In addition, Social Security will be required to provide additional information about Medicare Savings Programs to applicants, and Social Security staff will receive additional training about Medicare Savings Programs.

Improvements to the Part D Low-Income Subsidy

The Part D low-income subsidy (LIS) is a vital program for ensuring that needy seniors and people with disabilities have affordable prescription drug coverage. MIPPA makes several changes to boost enrollment in the low-income subsidy.

- **Life Insurance Eliminated as a Countable Asset, Effective January 2010**
  Currently, the asset test for the Part D low-income subsidy includes the cash value of an applicant's life insurance as a countable asset. This provision creates hassle for applicants, who must contact their life insurance company to determine their policy's cash value, if any. Beneficiaries may also be disqualified because the cash value of their policy puts them over the asset limit. Effective January 2010, this provision will be eliminated.

- **In-Kind Support and Maintenance Eliminated as Countable Income, Effective January 2010**
  Currently, low-income subsidy applicants must estimate the value of in-kind support they receive, such as groceries paid for by an adult child. This question is seen as intrusive by many applicants and discourages completion of an application. Starting in January 2010, this question will be eliminated.

- **Elimination of the Part D Late Enrollment Penalty for Low-Income Beneficiaries, Effective January 2009**
  An estimated 2.6 million low-income beneficiaries have not yet signed up for Part D coverage.[2] If they were to sign up now, many of them could be subject to a late enrollment penalty. Every year, since Part D began in 2006, however, Medicare has waived the penalties for low-income beneficiaries in order to encourage enrollment. In order to ensure that this policy continues in the future, MIPPA permanently eliminates the Part D late enrollment penalty for low-income beneficiaries.

- **Funding for Outreach and Enrollment**
  MIPPA allocates a total of $25 million for increased outreach to Medicare beneficiaries, the bulk of which is to be targeted at reaching low-income beneficiaries. The agencies receiving funds are State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging, and Aging and Disability Resource Centers. Funds will also go toward a new initiative to provide coordinated information about benefits to older Americans.

Other Improvements to Medicare's Benefits

- **Mental Health Coinsurance Parity, Phased in from 2010 to 2014**
  Currently, Medicare beneficiaries must pay coinsurance of 50 percent for outpatient mental health services. This is substantially more than the 20 percent they pay for most other outpatient medical care. MIPPA will gradually correct this inequity by phasing coinsurance rates for mental health services down to 20 percent by 2014.

- **Flexibility to Add Preventive Services, Effective January 2009**
  The legislation allows Medicare to cover additional preventive services without congressional action.

- **Benzodiazepines and Barbiturates Covered by Part D, Effective January 2013**
  Currently, Part D does not cover benzodiazepines and barbiturates. Effective January 2013, Part D plans will be allowed to cover benzodiazepines, and barbiturates under certain conditions.

Addressing Health Disparities

Communities of color account for over 20 percent of Medicare beneficiaries. Although Medicare covers nearly all individuals over age 65 with the same standard benefits, numerous studies have shown that people of color do not always fare as well under the program. As the single largest purchaser of health care in the United States, Medicare has tremendous potential to reduce racial and ethnic disparities in health. Below, we outline a few ways that MIPPA will seek to address health and health care disparities in the Medicare program:

Improved Data Collection for Measuring and Evaluating Health Disparities

The Secretary of Health and Human Services (HHS) will be required to evaluate the best methods for data collection and submit those findings to Congress for implementation. In order to meet this requirement, data collection and evaluation should be ongoing, accurate, and timely. It also should include ways to measure disparities in health care and performance on the basis of race, ethnicity, and gender in the Medicare program.

Outreach to the Previously Uninsured

Because people of color are more likely to be uninsured, it is important for the Medicare program to reach out to and enroll those who lack coverage. The Secretary will research the most effective ways to reach individuals who did not have health insurance prior to Medicare and to determine their greatest needs in terms of health care. Results from this study will be submitted to Congress.

Compliance with Cultural Competency Standards

Under MIPPA, the HHS Inspector General will report on how well Medicare providers and plans are meeting cultural competency standards set by the Office of Minority Health and the Office of Civil Rights. The report will provide recommendations to help providers meet these standards and also detail the savings or costs that health care providers incur when they provide language services for patients.

Grappling with Medicare Advantage

The size and number of private Medicare Advantage (MA) plans has increased rapidly in recent years. On average, it costs 13 percent more to provide care through these plans than through traditional Medicare.[3] There is little evidence, however, that they produce better health outcomes. MIPPA takes steps to make Medicare Advantage plans more accountable and to rein in the rapid growth of some of the most dubious varieties of Medicare Advantage plans. It does not, however, make significant changes in payment formulas to Medicare Advantage plans.

■ Slowing the Growth of Private Fee-for-Service Plans

Private fee-for-service plans (PFFS) are the fastest growing and most expensive type of Medicare Advantage plan. They have no provider networks and are not required to coordinate care. They have also been responsible for some of the most egregious marketing abuses that have lured seniors into inappropriate plans.

MIPPA slows the growth of private fee-for-service plans and steers them towards a more rational model of care. Starting in 2011, private fee-for-service plans will be required to have networks of providers, like other managed care plans have, except in regions of the country where there are fewer than two other network-based Medicare Advantage plans.

■ Indirect Medical Education (IME) Double Payments Eliminated

For years, Medicare Advantage plans that have teaching hospitals in their plans have been receiving payments to cover the supposedly higher cost of delivering care in these settings. These payments are in addition to payments Medicare makes directly to these hospitals. MIPPA eliminates this double payment, leaving the direct payments to teaching hospitals in place.

■ Controls on Special Needs Plans

Special Needs Plans (SNPs) are Medicare Advantage plans that are permitted to serve only specific types of Medicare beneficiaries (for example, those with chronic conditions, in institutions, or who receive Medicare and Medicaid). Special Needs Plans have proliferated since 2006 with little oversight.[4] MIPPA imposes new standards on Special Needs Plans, including limiting the populations they can serve and requiring more rigorous models of care management.

■ Consumer Protections in Medicare Advantage Marketing

Medicare Advantage plans and their brokers and agents have employed many unethical and fraudulent practices in their pursuit of new members, from door-to-door sales to forging beneficiaries' signatures.[5] As a result, beneficiaries have lost access to providers or been stuck with large bills. MIPPA codifies consumer protections and gives them the force of law, including prohibiting unsolicited calls and door-to-door sales, restricting where marketing can take place, and tightening training and compensation rules for brokers and agents.

Conclusion

On balance, MIPPA is a significant step forward for people with Medicare. Low-income beneficiaries and other vulnerable populations are particularly helped by it. But much work remains to be done. The MIPPA provisions must still be implemented by the federal government and the states. Decisions made during implementation will determine how large a positive impact the legislation will have. There is also much to build on for future legislation, to better serve those who rely on Medicare.

To view the full text of the Medicare Improvements for Patients and Providers Act (MIPPA), PL 110-275, go to www.govtrack.us/congress/billtext.xpd?bill=h110-6331.

---

[1] Ebeler, Jack, Paul N. Van de Water, and Cyanne Demchak (eds.), *Improving the Medicare Savings Programs* (Washington: National Academy of Social Insurance, 2006).

[2] Kaiser Family Foundation, *The Medicare Prescription Drug Benefit Fact Sheet* (Washington: Kaiser Family Foundation, February 2008), p.2.

[3] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington: Medicare Payment Advisory Commission, March 2008), p. 246.

[4] Charles Milligan Jr, and Cynthia Woodcock, *Medicare Advantage Special Needs Plans for Dual Eligibles: A Primer* (New York: The Commonwealth Fund, February 2008).

[5] United States Senate Special Committee on Aging, *Committee Print: Medicare Advantage Marketing and Sales: Who Has The Advantage?* (Washington: U.S. Government Printing Office, May 2007).

FamiliesUSA
The Voice for Health Care Consumers

1201 New York Avenue NW, Suite 1100 ■ Washington, DC 20005
Phone: 202-628-3030 ■ E-mail: info@familiesusa.org
www.familiesusa.org