Chapter 4 Medicare Advantage & Part D

Coverage under Medicare is similar to that provided by private insurance companies: it pays a portion of the cost of medical care. Often, deductibles and coinsurance (partial payment of initial and subsequent costs) are required of the beneficiary, thus the need for additional insurance coverage.

Part A of Medicare is financed largely through federal payroll taxes paid into Social Security by employers and employees. Part B is financed by monthly premiums paid by Medicare beneficiaries and by general revenues from the federal government. In addition, Medicare beneficiaries themselves share the cost of the program through co-payments and deductibles that are required for many of the services covered under both Parts A and B. Thus, the beneficiary can choose how to receive care.

A beneficiary can also choose to receive Medicare coverage and care through a Medicare Advantage plan by filing an enrollment form. Once the choice is made, the beneficiary generally must receive all of his or her care through the plan to receive Medicare coverage. Beneficiaries can also change their minds, disenroll from their Medicare Advantage plans, and return to Original Medicare.

Medicare Part C - Medicare Advantage

Under the Balanced Budget Act of 1997, Congress passed a law that made many changes in the Medicare program. This law included a section called Medicare+Choice (renamed Medicare Advantage, or MA, in 2003) that created new health plan options called Part C. A person enrolled in a Part C Medicare Advantage plan is still assured all of the basic benefits of Original Medicare—Parts A and B. In addition, Part C helps cover preventive care services to help the insured stay healthy at no extra cost and several MA health plan choices.

Medicare+Choice expanded options for receiving Medicare coverage through a variety of managed care plans, including health maintenance organizations (HMOs) and preferred provider organizations (PPOs), and through new mechanisms such as Medicare medical savings accounts. The Medicare Modernization Act of 2003 changed the name of Medicare+Choice to Medicare Advantage (MA).

To be eligible for the Medicare Advantage choices, an insured must have Medicare Part A (Hospital Insurance), and/or be eligible for Medicare Part B (Medical Insurance), and must not have end-stage renal disease. The choice of plans is up to each individual. No matter what an insured decides, he or she will still be in the Medicare program and will receive all the Medicare-covered services.

Medicare Advantage provides an alternative way for beneficiaries to receive and pay for Medicare coverage, services, and benefits. Essentially, it combines into a single plan the payment for the costs for an individual's Medicare coverage with the delivery of the Medicare services and benefits. Medicare Advantage plans are offered by private insurance companies that contract with hospitals, physicians, and health care service providers. All Medicare Advantage plans must cover all of the benefits of traditional Medicare Parts A and B; they may also offer additional benefits. MA enrollees are actually considered outside of traditional Medicare; therefore, when they go to a provider, they present their Medicare Advantage ID card rather than their red, white, and blue Medicare card.

Growth of Medicare Advantage Plans

Since its inception in 1965, Medicare has provided a set of coverage and due-process protections so that all beneficiaries could expect the same basic level of health insurance. As a consequence, all beneficiaries—rich or poor, well or sick—had a common interest in making the program work. This system resulted in the evolution of an imperfect, but functional, basic health insurance

program for all people age 65 and over and those under age 65 who are disabled or suffering from end-stage renal disease. But, as time progressed and medical expenses rose far above normal inflationary rates, the program became extremely expensive. Thus, in reaction to rising costs, and in an attempt to curb them, Congress and Medicare developed Medicare Part C.

During the late 1990s, an increasing number of Medicare beneficiaries transferred their health needs to managed care plans. The Medicare managed care benefit was different from the traditional Original Medicare fee-for-service ongoing plan, but basic coverage generally remained the same. Some Medicare Advantage plans (HMOs and PPOs) permit beneficiaries to go directly to a specialized care provider, with the plan's approval, in return for payment of an extra charge. Others, such as private fee-for-service plans, have no requirement as to specific providers, although the providers must agree to accept the PFFS plan, and that factor may create a complication for the enrollee.

The methods for delivering and financing health care are in flux for all Americans. Medicare Advantage plans sometimes change their benefit packages due to certain circumstances, usually financial.

However, the growth of Medicare Advantage plans over the years of the program's revival has been overwhelming. From its inception in 1999 through 2017, the enrollment in Medicare Advantage had grown to over 21 million Americans. This is a significant trend, considering the head-start Medicare supplement had on additional Medicare coverage.

Medicare Advantage Options

Under Medicare Advantage, a Medicare beneficiary can choose to remain in his or her current managed care plan, or choose to receive Medicare covered services through any of the additional following types of health insurance plans. However, no matter which plan or type of plan the beneficiary chooses, he or she must be eligible for and maintain both Medicare Part A and Medicare Part B (i.e., pay the monthly Part B premiums to Medicare).

Producers should understand that a Medicare Advantage product or plan they represent may include a number of options with regard to three specific elements: the deductible, co-payments, and coinsurance. A plan's deductible is typically a fixed amount, though some plans may not require a deductible. A plan's co-payment, or "co-pay," is a set dollar amount that a plan participant pays to the provider of a covered service. A coinsurance amount is a percentage of the cost of the service provided that the insured is responsible for paying. Coinsurance amounts are typically 20 percent: the insured pays 20 percent of the cost and the plan pays 80 percent of the cost.

Coordinated Care Plans (CCPs)

Coordinated care plans (CCPs) are managed care plans that include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and regional PPOs. They provide coverage for health care services with or without a point-of-service option (the ability to use the plan or out-of-plan health care providers). Some plans limit the enrollee's choice of providers. Others may offer benefits, such as prescription drug coverage, in addition to those in the traditional Medicare program. Other plans limit the choice of providers and supplemental benefits. It is very important for the Medicare enrollee to analyze the coverage details, advantages, and disadvantages of each plan.

The enrollee should also be aware that there are basically two types of Medicare Advantage plans:

- -Network
- -Non-network

Network plans offer care to enrollees through their network of physicians and hospitals and are

identified as HMOs and PPOs. The non-network MA plan is a personal fee-for-service (PFFS) plan that (until 2011) did not require the enrollee to see a certain doctor or hospital, though the doctor or hospital they did choose had to be willing to accept the PFFS plan's payment structure. However, due to a later compliance ruling, non-network PFFS plans have largely disappeared from the Medicare Advantage scene.

In 2006, Medicare Advantage plan choices were expanded to include regional preferred provider organization plans (RPPOs). Regional PPOs help ensure that beneficiaries in rural and urban areas have multiple choices of Medicare Advantage health coverage. The PPO is a Medicare Advantage plan in which recipients use doctors, hospitals, and providers that belong to the network. The recipient can use doctors, hospitals, and providers outside of the network for an additional cost—a larger co-pay or coinsurance.

Before 2005, HMOs accounted for 80 percent of CCP contracts and 98 percent of CCP enrollments. CCPs continue to be highly utilized for delivering Medicare Advantage plans.

Following are the various Medicare Advantage plans in order of preference by utilization.

Health Maintenance Organizations (HMOs) With or Without Point-of-Service (POS)
A Medicare Advantage HMO plan is composed of its own network of doctors and hospitals that enrollees must use for most services. The enrollee must see the network primary care doctor and get a referral to see any other health care provider, except in an emergency. If the plan has a point-of-service (POS) option, the enrollee can go out-of-network but will have to pay more for services, possibly even full costs. If the enrollee's doctor leaves the plan, the plan will notify the enrollee, and the enrollee can choose another plan doctor. The cost of Part D is included in the premium paid for the plan. Some HMOs offer extra benefits in their programs. Funding for HMOs comes directly from CMS, per enrollee, per month, and is based on a benchmark allotment formula developed by CMS. HMOs are highly utilized for delivering MA plans.

Preferred Provider Organizations (PPOs)
A Medicare Advantage PPO plan is available in local or regional areas and is offered by a private insurance company. PPOs operate similarly and provide services similar to HMOs in that the enrollee can go outside of the network to receive care, usually at a higher co-pay or coinsurance cost. Regional PPOs were developed in MMA 2003 to enable people in rural areas to access care delivery similar to urban areas. Extra benefits, including Part D, can be offered for an additional premium; however, most Part D benefits are built into plan costs—not charged separately. Funding for PPOs from CMS is similar to that of HMOs.

Provider Sponsored Organizations (PSOs)
PSO plans, like HMOs, are owned and operated by hospitals and doctors that provide most of the services to the beneficiary; however, they're supposedly more user friendly than HMOs.

Private Fee-for-Service (PFFS) Plans
A private fee-for-service (PFFS) plan offers another alternative to Medicare Advantage enrollees. A PFFS plan is one that:

-Reimburses providers, on a fee-for-service basis, at a rate determined by the plan
-Does not vary rates for the providers based upon their particular utilization
-Providers agree to accept the terms and conditions of payment established by the plan and can do so on a case-by-case basis
-Can be utilized by network or non-network providers depending on the locality of the plan

The Medicare program makes capitated payments (fixed amounts per enrollee) to private fee-for-service plans, just as it does to HMOs and PPOs, based upon geographical, regional, and county benchmark payment criteria. These plans do not have to follow the usual Medicare fee limitations.

They establish their own rates, without reference to the Medicare Part B reasonable charge or limiting charge restrictions. The rates set by these plans may be higher or lower than those in the traditional Medicare program. Providers under contract with a private fee-for-service plan will be required to accept an amount not to exceed 115 percent of its contracted rate as payment in full for covered services (including any permitted deductibles, coinsurance, co-payments, or balance billing).

However, the provisions of MIPPA 2008 called for changes to private fee-for-service plans in some areas by requiring them to organize networks of providers and to have the same quality improvement programs as local PPOs. Also, the same law required them to demonstrate coordinated care with Medicare and Medicaid in relation to special needs plans (SNPs) for three classes of enrollees: institutional level recipients, dual eligible contracted individuals, and disabling chronic condition individuals. These requirements virtually eliminated PFFS plan flexibility, forcing them to operate in a manner similar to PPO plans; consequently, a number of Medicare Advantage companies were compelled to discontinue their PFFS plans in certain locations. This, in turn, resulted in nearly 1.6 million enrollees having to switch to PPO or HMO plans or return to Original Medicare and purchase a Medicare supplement policy. The final result is that enrollees must inform providers who are not in a network that they are PFFS plan members before receiving services so that the providers can decide whether to accept the plans terms and conditions to treat a patient on a patient-by-patient and visit-by-visit basis.

Special Needs Plans (SNPs)
SNPs must limit new enrollments to certain sub-populations of beneficiaries. Types of SNPs include:

-Dual eligible SNPs that service beneficiaries eligible for both Medicare and Medicaid (dual eligible)
-Chronic care SNPs that service beneficiaries with certain severe or disabling chronic conditions, such as diabetes
-Institutional SNPs that serve beneficiaries in long-term care facilities within the plan's network as well as beneficiaries living in the community who require an institutional level of care

All SNPs provide Part D Prescription Drug coverage. SNPs were, at one time, somewhat curtailed because abuses occurred where patients were put into SNP plans without developing a plan of care for that patient. Currently, SNP enrollments must abide by the plan-of-care rules.

Cost Plans (1876 Cost Plans)
Cost plans are HMOs that are reimbursed on a cost basis rather than on a capitated (per head) amount like other private health plans. Cost enrollees are allowed to receive care outside of their HMO and have those costs be reimbursed through the traditional fee-for-service system.

Preferred Provider Organization Demonstration Plans (PPO Demo), Private Contracts, and Other Demonstration Plans
These various plans are all technically a part of Medicare Advantage, but due to their limited singularity of purpose, they are not mainstream plans. They are primarily included as MA plans because their beneficiaries have needs outside the scope of Original Medicare.

Medicare Medical Savings Account Plans (MSAs)
Medicare medical savings account plans combine high-deductible MA policies with a medical savings account for medical expenses. Accordingly, MSAs consist of two components:

-A private MA insurance policy with high annual deductibles (as high as $12,000)
-A medical savings account

The MA health insurance policy does not pay covered costs until the deductible (which varies by plan) has been met. The second component of the plan, the medical savings account, comes into play when Medicare deposits money into an account for the enrollee (deposited into the tax-free MMSA account), which can then be used for any health care expenses, including the plan's deductible. Beneficiaries pay for medical bills out-of-pocket for the amounts under the deductible. Tax penalties are imposed for withdrawing money for any reason other than medical.

Religious and Fraternal Benefit Society Plans
Medicare Advantage plans may be offered by religious and fraternal organizations. These organizations are able to restrict enrollment in their plans to their members.

Scope of Coverage

Medicare Advantage plans, except for private contracts, must provide coverage for all services currently available under Medicare Parts A and B. Plans must inform their enrollees about the availability of hospice care, including whether a Medicare-participating hospice program is located within their service area or whether it is common to refer outside the area.

Plans must pass on to beneficiaries any cost-savings achieved through efficient plan administration in the form of additional benefits. Medicare Advantage plans may offer supplemental benefits, for which a separate premium may or may not be charged, but the separate premium cannot vary among individuals within the plan and must not exceed certain actuarial and community rating requirements. Part D Prescription Drug benefits may or may not be included in the benefits. At least one plan from any MA company must include Part D, except for PFFS plans, whose enrollees can utilize Part D stand-alone products, as well as service in the plan.

Included in the Patient Protection and Affordable Care Act is a provision that prohibits Medicare Advantage plans from charging higher cost sharing than Original Medicare charges for certain covered services such as chemotherapy, dialysis, and skilled nursing care. In addition MA companies are also subject to medical loss ratio scrutiny, which means that 85 percent of all premium monies received by the plan must be distributed to enrollees in the form of plan benefits. This determination will be performed by Medicare's recovery audit contractors (RACs) in the same way Medicare currently tracks payments to hospitals and doctors in Original Medicare fee-for-service.

Recent Changes
For their 2019 (and later) plans, MA companies are now allowed to expand the scope of their coverage and provide several types of non-health related items in their benefit plans. In a "first-ever" decision by Medicare, MA plans can now offer additional benefits that have traditionally been associated with long-term care and long-term care insurance. These benefits can include:

-In-home support services—services performed by a personal care attendant to assist disabled or medically needy individuals with activities of daily living or instrumental activities of daily living. Services must be performed by individuals licensed to provide personal care services, or in a manner that is otherwise consistent with state requirements.

-Home-based palliative care—services not covered by Medicare in the home for palliative care (comfort care) to diminish symptoms of a terminally ill enrollee with a life expectancy of more than six months.

-Transportation for (non-emergency) medical services—transportation to obtain Part A, Part B, Part D, and supplemental benefit items and services. The transportation must be used to accommodate the enrollee's health care needs; it cannot be used for non-medical services, such as buying groceries or running errands.

-Home safety devices and modifications—safety devices to prevent injuries in the home and/or bathroom. The modifications must be non-structural and non-Medicare covered. This benefit can include a home and/or bathroom safety inspection to identify any need for safety devices or modifications.

In order to be covered by the plan, these supplemental benefits must be recommended by a physician or licensed medical professional.

This expansion of allowable benefits and coverages was not announced until mid-2018—too late for most MA companies to make changes to their 2019 plan offerings. It is expected that the inclusion of some of these new benefits in MA plans will be more pronounced in 2020 and later.

The Basics of Medicare Advantage Plans

Eligibility
Generally, a Medicare beneficiary is eligible to enroll in a Medicare Advantage plan if the following two conditions are satisfied:

1. The beneficiary is entitled to Medicare Part A and is enrolled in Medicare Part B as of the effective date of enrollment in the Medicare Advantage plan.
2. The beneficiary lives in the service area covered by the Medicare Advantage plan.

There are some exceptions to the general rule, though, and some other eligibility rules. For example, a Medicare beneficiary is not normally eligible to enroll in the Medicare Advantage plan if he or she has end-stage renal disease (ESRD)—that is, permanent kidney failure that requires regular kidney dialysis or a transplant to maintain life. However, if an individual is already enrolled with the Medicare Advantage organization when he or she develops ESRD, and this individual is still enrolled with the Medicare Advantage organization at the time, he or she can stay in the existing plan or join another plan offered by the same company.

Enrollment Periods
An eligible individual can enroll in the Medicare Advantage plan at the following times:

-Initial election period (IEP)—The IEP is also known as initial coverage enrollment period. The key word is "initial." A person can elect to enroll in a Medicare Advantage plan when he or she first becomes entitled to both Part A and Part B of Medicare. The initial election period begins on the first day of the third month before the date on which he or she is entitled to both Part A and Part B and ends on the last day of the third month after the date that the person became eligible for both parts of Medicare. Three months before, the month of, and three months after, creates a seven-month initial election period. This is the same election period as Medicare itself. Prospects within this initial period do not need to wait for any other enrollment period. Coverage begins on the first day of the enrollee's birth month. For disability enrollees, there is also a seven-month enrollment window from the time the individual starts receiving Medicare disability benefits. annual coordinated election period (ACEP or AEP)—The ACEP or AEP is when Medicare beneficiaries can elect to enroll, drop, or change their enrollment in a Medicare Advantage and/or Part D plan. This period runs from October 15 through December 7 every year. Coverage begins on January 1 of the following year.

-Open enrollment period—The open enrollment period is another period when current Medicare Advantage members can make changes to their enrollments. Prior to 2019, there was an annual Medicare Dis-enrollment Period, which ran from January 1 to February 14 every year. This has been replaced with a different arrangement: Medicare Advantage Open Enrollment. This new period runs from January 1 to March 31 every year, during which time current MA or MAPD

enrollees can:

-Enroll in a different MA plan, with or without drug coverage
-Drop their MA plan and return to Original Medicare, Parts A and B
-Sign up for a stand-alone prescription drug plan if they return to Original Medicare

The advantage to the open enrollment period is that those who joined an MA or MAPD plan during the annual election period and find that they don't want that plan now have a 90-day window to drop or switch an MA or MAPD plan, as opposed to 45 days as was the case under the prior dis-enrollment period. Any changes become effective the first month after the plan receives the request.

This new open enrollment period does not apply to those who are enrolled in Original Medicare—that is, Original Medicare enrollees cannot use this period to switch to a Medicare Advantage plan, nor can they make any changes to their enrollment in an existing prescription drug plan. Insurance companies and producers cannot actively market during this open enrollment period to encourage beneficiaries to switch plans.

-Special election period (SEP)—SEPs are special periods during which a person is permitted to enter into or to discontinue enrollment in a Medicare Advantage plan and change his or her enrollment to another Medicare Advantage plan or return to Original Medicare. The person can enroll in an MA plan if he or she is recently disabled or can begin receiving assistance from Medicaid, and he or she does not have to wait until the October 15 ACEP enrollment period. These circumstances are commonly referred to as "life events." In the event of the following circumstances, a special election period is warranted:

-The MA plan that the member is enrolled in is terminated. This is termed involuntary dis-enrollment, which results in involuntary loss of creditable coverage for the member.

-The enrollee permanently moves out of the service area or continuation area of the MA plan, recently moved into the service area, or recently returned to the United States after having lived permanently outside of the United States.

-The Medicare Advantage company offering the plan violated a material provision of its contract with the enrollee.

-The enrollee meets such other material conditions as CMS may provide, such as an involuntary loss of creditable group coverage, or a delayed enrollment due to an employer's or union's coverage or spouse's employer group health insurance coverage being terminated.

-The individual experienced a recent disability.

-The individual is receiving any assistance from Medicaid. This includes the following:

-Full dual eligible
-Partial dual eligible (Medicare Savings Program enrollees)
-Beneficiaries residing in long-term care facilities

-The individual meets other qualifications relating to long-term facilities, creditable coverage, LIS (low-income subsidy) eligibility or loss of such; loss of Part D coverage; and other circumstances that give CMS discretion to create an SEP.

Dis-enrollments Under the 5-Star Rating System

There is another option for MA dis-enrollment or switching. Medicare uses a "star" rating system for Medicare Advantage and Medicare prescription drug plans to indicate the quality of a plan's

performance. All plans are rated on a one- to five-star scale, with one star representing poor performance and five stars representing excellent performance. An enrollee may switch from an existing plan to a five-star plan at any time during the year. However, it's possible that enrollees may not be able to find a five-star plan in their area. Even though the enrollee may make this switch at any time of the year, he or she can only make the selection one time during the year. The new rule applies to Medicare Advantage plans, Medicare Advantage prescription drug plans, and stand-alone prescription drug plans. In addition, a producer who represents a five-star plan is allowed to market that plan any time during the year that the company achieves and continues to maintain the plan's five-star rating.

Voluntary Dis-enrollment
Medicare Advantage plan members can end their membership for any reason. If they want to disenroll, they should write a letter or complete a dis-enrollment form and send it to their plan's Customer Service department. The date of their dis-enrollment will depend on when the plan receives the written request to disenroll. In general, written requests to disenroll must be received by the Medicare Advantage plan no later than the tenth of the month to be effective the first of the next month. Written requests to disenroll that are received after the tenth of the month will be effective the second month after the request is received.

An exception to this general rule is that dis-enrollment requests received between November 1 and November 10 are usually effective December 1. However, because the month of November is also the annual election period, enrollees can ask for a January 1 effective date.

Even though a person has requested dis-enrollment, he or she must continue to receive all covered services from the contracting medical providers until the date his or her dis-enrollment is effective. The person will be covered by Original Medicare after this unless he or she has joined another Medicare Advantage plan.

Other Voluntary Dis-enrollment Factors
In addition, other factors are involved in voluntary dis-enrollment For instance, suppose a Medicare beneficiary's first Medicare enrollment was in a Medicare Advantage program. Then he or she decides to disenroll from the program and enroll in Original Medicare. Within the first 12 months of coverage, the beneficiary has a 63-day opportunity to purchase any Medicare supplement plan within the scope of the plans that the carrier offers, on a guaranteed basis.

Or, suppose a person originally enrolled in Original Medicare and a Medicare supplement program, and then he or she decided to switch to Medicare Advantage. Then the person decides to switch back to Original Medicare. In this case, the individual may, within 12 months after that decision, go back to Original Medicare and the same Medicare supplement offered by the same MS carrier as before, if the person had been in the Medicare Advantage plan for less than a year.

A problem that may arise involves Part D coverage. If a person decides to use the one-year guarantee to switch out of Medicare Advantage, then CMS rules do not permit him or her to disenroll from the Prescription Drug program. In that case, the person must complete a stand-alone Part D application and mark the "Special Election Period (SEP)" oval that is in the "Office Use Only" portion of the application. CMS will then use the SEP on the Part D application to begin the process for the MA dis-enrollment and return the person to Original Medicare. (This SEP procedure is also available when enrolling in an MA plan when receiving Medicaid assistance or when receiving Medicare disability at any time during the year.)

If individuals want to voluntarily disenroll during the new Medicare Advantage open enrollment period (January 1 to March 31), they may do so by writing or calling their plan or by calling 800-Medicare; however, a written request for dis-enrollment may be required. The MA company must provide a dis-enrollment notice within seven days of receiving the request. If the person wants to return to Original Medicare and obtain a Medicare supplement policy, the Medicare supplement

company will require that he or she complete the MA questions on the Medicare supplement application. The company will then require one of the following:

-A copy of the person's MA plan dis-enrollment notice
-A copy of the letter that the person sent to his or her MA plan requesting dis-enrollment
-A signed statement verifying that the person has requested to be dis-enrolled from his or her MA plan

If a person dis-enrolls later than the March 31 cutoff date, a copy of his or her MA plan dis-enrollment notice will be necessary.

Moves or Extended Absences
If individuals are permanently moving out of the Medicare Advantage service area or plan an extended absence, it is important that they notify the provider of the move or extended absence before they leave the service area for a period of more than six months They may be eligible to continue to receive benefits if they are in the plan's continuation or network area.

Failure to notify the Medicare Advantage organization of a permanent move or an extended absence may result in a person's involuntary dis-enrollment from the plan. The plan is required to disenroll a person if he or she permanently moves outside the service area. An absence from the service area of more than 12 months is considered a permanent move. If individuals remain enrolled after a move or extended absence and have not been involuntarily dis-enrolled as described, then they should be aware that services will not be covered unless they are received from a Medicare Advantage plan provider in the Medicare Advantage plan service area (except for emergency services, urgently needed services, out-of-area dialysis, and prior authorized referrals).

Involuntary Dis-enrollment
The Medicare Advantage organization may disenroll an insured from a plan only under the conditions listed below:

-The insured moves permanently out of the service area and does not voluntarily disenroll.

-The insured temporarily moves out of the service area for an uninterrupted absence of more than six months. In cases such as "snow bunnies" who move to a warmer climate in the winter months, enrollees can inform their MA ahead of time that they will temporarily be out of the service area and the MA company will likely accept that information as a reason not to terminate the enrollee.

-The insured's continuation of coverage of Part A is terminated.

-The insured's entitlement to Medicare Part A or enrollment in the Part B benefits ends.

-The insured supplies fraudulent information or makes misrepresentations on his or her individual election form that materially affects the person's eligibility to enroll in a Medicare Advantage plan or Medicare Parts A, B, and D.

-The insured is disruptive, unruly, abusive, or uncooperative with regard to his or her membership in the Medicare Advantage plan, and the behavior seriously impairs the provider's ability to arrange covered services for the person or other individuals enrolled in the plan. Involuntary dis-enrollment on this basis is subject to prior approval by CMS.

-The insured allows another person to use his or her membership card to obtain covered service under Parts A and B.

-The insured fails to pay the plan premiums on a timely basis.

-The insured joins a stand-alone Medicare Prescription Drug plan, unless he or she is in a PFFS plan that does not include Part D coverage, or he or she is in a MSA plan.

-The MA company decides to terminate its plan, which renders the insured involuntarily dis-enrolled

Note that an insured will not be dis-enrolled due to health status. Dis-enrollment on the aforementioned grounds can only occur after the insured has been provided notice with an explanation of the reasons for the dis-enrollment and information on applicable grievance rights. No insured shall be dis-enrolled because of his or her health status or requirements for health care services. Any insured who believes he or she was dis-enrolled by the Medicare Advantage organization because of the insured's health status or requirements for health care services should bring the matter to the attention of the local CMS regional office.

Premiums and Payments
Enrollment in an MA plan is predicated on the enrollee's payment into the Medicare system. Consequently, enrollees must pay their monthly Medicare Part B premium (as well as Part A if they're not receiving Part A free of charge). Part B premiums are billed through Medicare and typically subtracted from enrollees' monthly Social Security or Railroad Retirement benefits. In addition, enrollees may be charged an additional monthly premium by the MA plan. This is typical if the plan provides benefits outside the scope of Original Medicare, such as prescription drug coverage or dental and vision care.

However, not all MA plans charge an additional premium. Many offer "zero premium plans," through which the plan is able to arrange for lower contracted payments to its providers (hospitals, physicians, etc.) with the savings passed on to the plan's enrollees.

In addition to their premiums, MA enrollees are usually obligated to pay their co-payments and co-insurance charges at the time service is rendered.

Annual Contract
The Medicare Advantage company's contract with CMS is reviewed and renewed annually. At the end of each contract year, the contract can be terminated by either the Medicare Advantage organization or CMS. If the Medicare Advantage organization ends the contract, insureds must receive a minimum 90-day notification before the end of the contract. If CMS ends the contract, insureds must receive a minimum 30-day notification, with an explanation of what their options are at that time. For example, there may be other Medicare Advantage plans in the area for them to join if they wish. Or, they may want to return to Original Medicare and possibly obtain supplemental health insurance. Whether an insured enrolls in another Medicare Advantage plan or not, there would be no gap in Medicare coverage. Until returning to Original Medicare coverage, the insured would still be a member of the Medicare Advantage plan. Important provisions are in place to protect insureds in cases that relate to guaranteed issue of a Medicare supplement policy after returning to Original Medicare.

The implication of annual plan contracting is important for producers to understand and explain to their clients. Because all MA and MAPD and stand-alone Part D plans are on a one-year contract between CMS and the MA-MAPD-PDP company, the provisions of the coverage, the coverage amounts, and plan's drug tiers (as well as the covered drugs themselves) will change from year to year. This is why Medicare advertises notices to remind people to examine their coverage each year and check to see if their plan renewal letters include any changes. Producers must be aware of any changes the companies they represent have made, to ensure their clients will be enrolled in the plan best suited for their needs.

MA Plan Appeals or Grievances

Members of a Medicare Advantage plan are encouraged to notify CMS if they have concerns or experience any problems with their Medicare Advantage plan. They can submit an appeal or grievance to the Medicare Advantage company for review and resolution, but certain procedures must be followed. The insured should begin these appeals and grievances with the Medicare Advantage plan customer relations department. Specific procedures include the following:

-General information on Medicare appeals procedures
-Medicare standard organization determinations and appeals procedures

-Medicare drug plan 72-hour determinations and appeals procedure

-The Medicare Advantage organization grievance procedure

-Quality improvement organization (QIO) immediate review of hospital discharges

-QIO quality of care complaint procedure

After MIPPA 2008, low-income subsidy beneficiaries are now allowed to have the same judicial review rights as other beneficiaries.

Moreover, a member of a Medicare Advantage plan has the right to appeal any decision about payment for or failing to arrange or continue to arrange for what he or she believes are covered services (including non-Medicare covered benefits) under a Medicare Advantage plan. Coverage decisions that are commonly appealed include the following:

-Payment for emergency services, post-stabilization care, or urgently needed services

-Payment for any other health services furnished by a non-contracting medical provider a facility that a person believes should have been arranged for, furnished by, or reimbursed by the Medicare Advantage organization

-Services that a person has not received but that he or she feels the Medicare Advantage organization is responsible for paying or arranging

-Discontinuation of services that he or she believes are medically necessary covered services

-Disagreement with the MA plan's decision regarding pre-authorization for some procedures

Medicare Part D-Prescription Drug Program

With the enactment of MMA 2003, Congress added a completely new coverage option—Medicare Part D—which provides coverage for prescription drugs. In addition to Medicare taking the prescription drug responsibility for low-income beneficiaries from the Medicaid program and transferring it to the Medicare program, Medicare offers prescription drug insurance coverage for Medicare beneficiaries. Plan D is available through "stand-alone" Part D plans or through some Medicare Advantage plans, known as MAPD plans.

Historically, Medicare had not covered outpatient prescription drug costs (except for one year—1989). Then, in 2003, Congress passed and the president signed the Medicare Prescription Drug Improvement and Modernization Act (MMA 2003), which expanded Medicare to include a prescription drug benefit. The prescription drug benefit began in 2006. Medicare (through laws established by Congress) reserves the right to define the care that it will cover, including that which is offered under Part D. In addition, all medical procedures and treatments are subject to Medicare's approval, which is why it is imperative to fully understand the program.

In a 12-page bulletin issued January 21, 2005, CMS released its "Final Rules Implementing the New Medicare Law: A New Prescription Drug Benefit for All Medicare Beneficiaries, Improvements to Medicare Health Plans and Establishing Options for Retirees." The first paragraph of the report summarized the intent of the law, and its content can be used as a starting point for our discussion of the Part D program:

"The U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) today issued the final regulations implementing the new prescription drug benefit that will help people with Medicare pay for the drugs they need. This benefit begins in January 2006 and allows all Medicare beneficiaries to sign up for drug coverage through a prescription drug plan or Medicare health plan. The final regulations also provide new protections for retirees who currently receive drug coverage through their employers or unions, and they strengthen the Medicare Advantage program."

Two significant points contained in this paragraph serve as the focus of our discussion. The first point is ". . . drug coverage through a prescription drug plan or Medicare health plan." This refers to utilization of the "stand-alone" Medicare Part D plan or utilization of a Medicare Advantage plan (to gain prescription drug coverage)—MAPD. The second point, ". . . new protections for retirees who currently receive drug coverage through their employers or unions," refers to the concern that employers would drop retirees from their existing group health insurance because of escalating prescription drug costs. We will address both of these statements separately in a moment.

A second paragraph in the "Final Rules" document summarized the outlook for the new program by stating the following:

"With the enactment of the MMA, and the final rules issued today, Medicare looks more like the rest of the American health care delivery system by giving beneficiaries the option of new, subsidized drug coverage, as well as new support to keep their current retiree coverage secure."

A final paragraph describing the implementation of the Part D plan has significance to both Medicare Advantage plan representatives and Medicare supplement producers:

"The Medicare Prescription Drug benefit: The final rules describe the plan options that beneficiaries will have to obtain their outpatient drug coverage. Prescription drug plans and Medicare Advantage plans will be required to provide basic coverage, but may also offer additional plans with supplemental coverage."

Medicare supplement producers should not confuse this paragraph with Medicare supplement plans—the paragraph addresses prescription drug plans. In this case, that means the prescription drug plans (Part D) that health insurance providers began offering to Medicare recipients beginning January 1, 2006. In other words, private companies (prescription drug providers, or PDPs) offer the Part D plans, and a Part D premium will pay for them; the paragraph does not refer to Medicare supplement companies. At least one Medicare Advantage plan per company was required to have the Part D benefit built into its offerings.

Part D Plan Enrollment
The initial enrollment period for Part D is the same as the initial enrollment period for Medicare: it is the seven-month period that begins three months before the month the individual turns 65, includes the birthday month, and ends three months after the month the individual turns 65.

Late Enrollment Penalty
It is important to note that those who do not take advantage of the initial Part D enrollment period at the time they first become eligible will pay a penalty premium if and when they do later enroll.

The penalty is an increase in the premium equal to an additional 1 percent per month (cumulatively) for each month they delay enrollment, unless they could prove creditable coverage from an existing plan, such as an employer-sponsored group health insurance program. The 1 percent is based on the national base benchmark premium for each year ($32.74 for 2020). As an example, currently and in the future, anyone who delays enrollment for three years (36 months) will see a 36 percent additional charge in their monthly premiums. In short, the Part D premiums are surcharged for late enrollees, and the amount charged at the time of enrollment is cumulative. In other words, the additional charge is added in perpetuity.

Why would someone delay enrollment? Suppose an enrollee believes she does not need Part D at age 65, because she feels completely healthy and does not use prescription drugs. Then, at age 78, conditions arise that indicate a need for Part D coverage. The result is a 156 percent premium surcharge for the 156 months of delayed enrollment. The premiums for the Part D coverage alone can become a financial hardship when the surcharge is added, as can the inflationary increases in the price of the prescription drugs.

The 1 percent per month premium surcharge penalty for late enrollment in a Part D plan is waived if the enrollee had prior "creditable coverage," as might be available under an employer plan, and did not go for more than 63 days without such creditable coverage before enrolling in Part D. For employer-provided or union-provided drug coverage to be considered "creditable," its actuarial value must at least equal the actuarial value of basic Part D coverage. The determination of whether or not the group plan is "creditable" is made by Medicare.

A problem can arise if a person continues his or her group health plan under COBRA because the prescription drug benefits of the group plan may not be considered as creditable—which then could result in the 1 percent per month penalty for late Part D enrollment.

Basic Foundations of Medicare Part D
Title I of MMA 2003 describes the parameters of the act:

-MMA 2003 established a voluntary prescription drug benefit.

-The benefit is for outpatient drug purchases.

-The beneficiary must be enrolled in Part A and/or Part B of Medicare.

-Coverage is available through two options:

1. Stand-alone private prescription drug plans (known as PDPs), which offer drug-only coverage, and the beneficiaries remain in traditional Medicare for their Part A and Part B services

2. Medicare Advantage plans, which offer both prescription drug and health care coverage (known as MAPD plans) and combine or integrate the Part D prescription drug coverages with the coverage for Part A and Part B services

-Another type of Medicare Advantage plan can be offered: a Regional Preferred Provider Organization (Regional PPO) plan. Regional PPOs must follow special rules: (1) they must offer Medicare Part D prescription drug benefits; and (2) they must place a cap on annual beneficiary out-of-pocket expenditures on Medicare cost sharing.

-Every Medicare beneficiary must have access to a prescription drug plan, either through an MAPD plan in his or her region or through a stand-alone PDP.

-Both types of plans (PDP and MAPD) must offer a standard drug benefit but must have the

flexibility to vary the drug benefit within actuarial equivalency parameters.

-Assistance with premiums and cost sharing are provided to eligible low-income beneficiaries (this is low-income subsidy, or LIS, also known to Medicare as Extra Help).

-Covered Part D drugs are essentially the same drugs and biologicals that are approved for the Medicaid program. Drugs and biological products that are already paid by Medicare Part A or Part B are not included.

-Covered Part D drugs must be dispensed by a prescription and on an outpatient basis.

Medicare Part D Drug Benefit
Medicare has allowed four modifications to the basic standard plan of Medicare Part D, but these modifications must follow certain rules regarding construction of benefit packages and cost sharing. These modifications are known as:

-Alternative basic standard plan
-Alternative enhanced plans
-Alternative enhanced plans that offer supplemental prescription drug coverages
-Alternative enhanced plans that offer optional prescription drug coverage

One additional plan, called the fallback plan, can be offered in any region or in a local area of any region where a choice of at least two qualifying plans, one of which is a stand-alone PDP, does not exist. These plans can be offered by Medicare Advantage plans.

The four modification plans have a wide variety of complexities and differences. Only the basic standard plan is discussed here, because it is the basis on which the other variations are built. The basic standard plan is the most commonly described plan and is the foundation of the Part D program. Consider the following facts of the Part D basic plan:

-Part D premiums were originally set at an anticipated benchmark of $37 per month for the basic standard plan, but in actuality, the prescription drug providers obtained lower premiums through bidding for the first year. (Premiums, however, are expected to rise in the future as the costs of certain prescription drugs skyrocket.)

-CMS set the national benchmark premium at $32.74 a month for 2020. The annual deductible in 2020 was set at $435.

Not all MAPD and PDP plans are alike, especially with respect to the formulary (covered drugs and their tier assignments) used by companies. Additional differences will be found in “no deductible” plans and plans that are more expensive but pay through the coverage gap (i.e., the donut hole).

Example: Basic Standard Part D Plan
The following is a simplified outline of the basic standard Part D plan for 2020:

-The enrollee pays the first $435 as a deductible.

-After the enrollee pays the deductible, he or she is in the initial coverage period. During this period, the enrollee pays 25 percent of drug costs, and the plan pays 75 percent, up to a combined amount of $4,020, including the deductible.

-After the initial coverage period, the enrollee then enters the coverage gap. Prior to 2011, 100 percent of prescription drug costs were paid by the insured while he or she was in the coverage gap. Then in 2011, drug manufacturers and Part D insurers began to share a portion of the insured’s coverage gap costs in the form of discounts. As of 2020, 75 percent of the cost of

generic drugs will be paid by the Part D plan and the brand-name drug manufacturer will assume 75 percent of the costs of brand-name drugs while the insured is in the coverage gap. The insured pays 25 percent. The amount the enrollee and the plan both pay counts as out-of-pocket spending until spending reaches a total of $6,350 at which point the coverage gap ends, and the enrollee is now into catastrophic coverage. (Note that in 2020, the coverage gap still exists but drug companies are required to pick up more of the cost.)

-At the catastrophic coverage point, the enrollee pays either 5 percent or $3.60—whichever is greater—for generic drugs and $8.95 for all other drugs through the end of the year.
Most MAPD or stand-alone PDPs are likely to be very different from the standard basic plan as they are allowed to vary their offerings and provisions from the basic plan. In reality, a producer will probably never see a "standard" plan, because most companies' offerings differ in many ways.

The above only describes the Part D basic standard plan for 2020. But, for most Part D plans, the producer will see several variables, such as no deductible plans (or plans that require a deductible for only higher tiered drug levels). For example, a plan might impose a deductible only for Tiers 4 and 5, and no deductible for Tiers 1, 2, and 3.

Tier 1 – Preferred generic drugs
Tier 2 – Generic drugs
Tier 3 – Preferred brand drugs
Tier 4 – Non-preferred brand drugs
Tier 5 – Specialty drugs

The producer may also see differences in copay amounts between "Preferred Pharmacies" and "Standard Pharmacies," and variations in payments (lesser) for mail-order drugs.

Some Important Considerations for Producers
Producers must remember that not all drugs are included in a plan's formulary, and for plan year 2020, some high-priced drugs have been removed from plan formularies. This situation is particularly evident with respect to high-cost cancer drugs; even the cost of some generic drugs that have been used for years has increased by as much as 1,000 to 5,000 percent. So, a genuine and diligent search of a plan formulary for clients is more important than ever.

Producers must also be aware of changes in the tier structures of a particular drug. In recent years, for example, many of the generic tier 1 and tier 2 drugs were moved into more expensive tier 3 and tier 4 categories.

As with Medicare Advantage plans, CMS's contracts with Part D plans are written on an annual basis. Consequently, premiums, deductibles, co-pays, coinsurance amounts, and donut hole costs paid by the insured may, and probably will, change from year to year.

A Note of Caution Regarding Switching People Out of Group Health Plans
A Medicare Advantage producer must remember, at all costs, not to switch retirees from their group health plan, a spouse's group health plan, or a union health plan to a Medicare Advantage plan without the approval of the human resources department or the group health plan's knowledge. This action may trigger (and has triggered) a loss of the entire package of group health benefits available to the retiree and eliminates any chance of the retiree returning to his or her original group health plan. The same is true for a stand-alone Part D plan. There is a requirement in the MA/MAPD/PDP enrollment process that the producer read the section to the enrollee regarding group employer or union coverage. The producer cannot afford to overlook this requirement because of the damage it may cause the enrollee.

It is important to note that producers should let Medicare Advantage or Part D plan enrollees know that they can receive help paying for their drug costs by contacting the Social Security office or

their state or county office on aging or Medicaid to see if they would qualify for "Extra Help."

Medicare's Premiums and Benefits

Premiums

The Medicare Part B premium that enrollees pay is just one part of Medicare—the physician services part of the program. Over time, beneficiaries are going to be asked to pay a larger share of the costs of the program. One reason is that some of the benefits that were covered formerly in Part A were shifted to Part B, such as HHC services. These benefit shifts caused an increase in Part B premiums.

Part B premiums rose because Medicare expanded the Part B program, largely through significant preventive benefit increases and medical care cost inflation. In comparison to Part B premiums of the late '90s and early 2000s, significant increases had been the trend. But beginning in 2012, expense factors began to slow down for Medicare, and decreases or premium holding patterns had been the norm from 2012 to 2015. That pattern ceased to exist for 2016, when MedPAC ruled that Part B premiums needed be increased. The lower Part B premium will probably not hold for long as more members of the boomer generation become Medicare recipients.

For many receiving a Social Security monthly check in the $700 to $800 range, the increases in Part B premiums can outstrip the relatively small COLA (cost-of-living adjustment) increases in their Social Security income. Even though the "take-home" amount of the Social Security check is protected by a "floor of protection" (a "hold harmless" provision) that does not allow the benefit amount to decline because of Part B increases, the result is one of no inflation protection for the Social Security recipient in other areas. This is not an insignificant trend for the average retiree.

In 2018, CMS ceased creating anomalies (which had been created by different COLA increases prior to 2018) with different tier levels and settled at a $134 premium for everybody. Then, for 2020, the premium was increased to $144.60. Even though people who are "held harmless" will not see their premium go up to $144.60, all other payers will—including those who are categorized as "High Earners," who will see far greater increases in their Part B premiums.

Most beneficiaries pay no premiums for Part A, having qualified automatically by Social Security or Railroad Retirement FICA (tax) payments (or "contributions" as the government calls them) during the course of a working lifetime. Only about 1 percent of beneficiaries buy into the system with Part A premium payments, with the amount depending on how many quarters of Social Security or Railroad Retirement coverage they were short. It is important to note that many ideas have been developed to address the fiscal problems of Medicare. Among those ideas is a concept to introduce a Medicare Part A premium, which would be a first for the Medicare program. Also, some thoughts have surfaced to combine Part A and Part B. This is unlikely, because it would require a restructuring of the entire Medicare program.

Benefits and Costs

In the last few years, several cancer screening and other preventive benefits have been added to Medicare. Benefits now include annual mammograms. In years past, Medicare paid for these types of benefits every two years, including cervical cancer screenings and prostate cancer screenings. Benefits now include a diabetes self-management program, which includes education and supplies for diabetics to help them better cope with their disease. With the addition of the annual wellness "prevention" benefits at no cost to the Medicare recipient, the preliminary costs are expected to be greater for Medicare early on but less in the long run, because prevention measures will hopefully minimize the need for greater care later.

Medicare used to be called the "sickness model": it paid for individuals when they got sick. However, the health care system, in general, is changing, with more emphasis on prevention. Congress has made an effort to create a more comprehensive preventive benefit package for

Medicare. MMA 2003 and PPACA 2010, added several further preventive benefits, which were previously discussed.

Expenditures created by taking on the prescription drug obligations of Part D and transferring some 6 million people from Medicaid to Medicare for prescription drug expenditures contributed to a jump in Medicare expenditures starting in 2006. However, in reality, these figures are only a fraction of the problem. The first of the nation's baby boomers started to collect Medicare benefits in 2011, and by 2030, an additional 78 million will be added to this program.

Expectations were that Medicare expenditures would total around $591 billion for 2013, even though the number of enrollees "only" grew by about 4 million, due to the baby boomers starting to enter the system. By 2018, Medicare recipients totaled over 59 million, and Medicare spending grew to approximately $731 billion according to the Henry J. Kaiser Foundation.2 Four factors have contributed to this expenditure growth:

-First, the growth of the Medicare population itself created more costs.

-Second, overpayments, fraud, improper payments, and waste had become rampant during the last half of the decade, which were estimated to run as high as $50 billion to $60 billion by 2018.

-A third factor was the large amount of money available to Medicare Advantage and Part D Prescription programs.

-Fourth, the ACA created several layers of "preventive" benefits, covered fully by Medicare with no deductible or co-pay responsibility to the patient.

Medicare's Costs and Payments

Efforts to rein in costs have proved politically difficult. Congress has enacted measures over the past two decades to combat the ever-increasing costs of Medicare by:

-Restructuring hospital payments in 1983 (prospective payment system, DRGs)
-Restructuring physician payments in 1989 (Physicians Reform Act)
-Restructuring payments for home health care, nursing home care, and hospital outpatient care, which are getting to be a larger and larger portion of the Medicare program (OBRA 96, BBA 97, HIPAA 97, MMA 2003, PPACA 2010)
-Restructuring home health care payments (prospective payment system)
creating effective fraud and recovery legislation, which gives CMS and its legal units the ability to pursue overpayments and fraud through several new programs
cutting $117 billion from Medicare Advantage payments as called for in PPACA 2010 (Actually, Medicare Advantage payments increased by a great amount starting in 2016.)
-Introducing "value based care" in 2015, implementing changes in doctor payments for such items as "bundled care," which capitated some costs as opposed to fee-for-service payments

During 2016, Congress passed MACRA (Medicare Access and CHIP Reauthorization Act) that eliminated SGR (Sustainable Growth Rate) rules, which had for 13 years dictated how much doctors were going to be paid, and instituted two new ways that doctors could choose to be paid.

In the past, all health care providers had been paid based on what they charged, and it was found that if they were given the money based on what they charged, they kept increasing their charges. With the aforementioned legislation, Congress voted to no longer do that for hospitals, doctors, home health care agencies, or for nursing homes and hospital outpatient costs. Currently, Medicare pays all providers a certain rate based on a fee-for-service formula for each U.S. zip code. Structured payments, such as those made to Accountable Care Organizations (where groups

of health care professionals collaborate to tend to all of a patient's needs), are becoming the modern way of addressing costs. Under such an arrangement, Medicare pays an agreed-upon, per-patient amount, and the ACO providers sort out the distribution of the payment. This structure does not relate to Medicare Advantage plans except for those that utilize ACOs.

In 2015, CMS announced a new system of "value based care," which was to be implemented over the next three years. This will replace the fee-for-service method that has been prevalent since Medicare's inception. Value based care includes Accountable Care Organizations and several other techniques such as "bundled payments." The intent was for 30 percent of Medicare payments to be achieved by the value based technique in 2016, 50 percent in 2017, and 70 percent by 2018. This was an ambitious attempt to get some of Medicare's costs under control, and CMS has indicated that the technique is working to reduce Medicare costs.

The Outlook for Medicare

It is impossible to predict what will transpire with Medicare more than a few years into the future. Several factors, including the impending stampede of baby boomers into Medicare, which started in January 2011, will have more than a considerable impact on this important program. The impact will also be felt by all those under age 65—the majority of the nation's taxpayers:

-The number of Medicare enrollees in 2018 was about three times as many as in 1970.

-Over the same period—1970–2018—Medicare expenditures increased from $7.5 billion to over $700 billion. Whereas enrollments increased 3 times, expenditures increased 93 times. These statistics are eye-opening enough, but they only represent the past. Medicare has increased its own burden, starting about 15 years ago, and has dramatically expanded its promises in the first few years of the twenty-first century. The full impact of benefits brought on by the promises of MMA 2003—Medicare Advantage plans and Medicare Part D—began to show themselves starting in 2006. The full impact of the "no deductible, no co-payment" preventive benefits that were added by PPACA has begun to show itself. These promises will probably continue to manifest in greater costs. When Medicare spending increased by 5.7 percent in 2015, it represented the first time that Medicare expenditures equaled 20 percent of the nation's gross domestic product (GDP).

-The expenditures of Part D, additional income provided to Medicare Advantage plans, the transferring of prescription drug benefits of dual eligibles from Medicaid to Medicare, additional services included in Original Medicare, the subsidies to American companies, outlandish costs for prescription drugs, and general medical care inflation amounts, which are far in excess of corresponding inflationary factors in the general economy, are crippling and, if not corrected, will soon strangle the Medicare program. In fact, the skyrocketing costs of Medicare forced Congress to consider cuts to all Medicare programs during most of 2009, during which time a total health care reform agenda dominated the political scene, and resulted in PPACA 2010.

But, all of these factors are minor compared to what is coming. In addition to the well-advertised baby boomer age wave, Medicare has a myriad of other problems to address. The health ravages of increasing obesity, the unprecedented growth in the rate of diabetes, increases in heart, hypertension, opioid addiction, and cancer diagnoses, extended longevity, and the general health care needs of an increasingly growing elderly population will stretch Medicare expenditures (and expectations) to impossible proportions. Medicare health care demands will be far, far greater than ever before. In fact, the American demand for quality health care may be replaced by the word "triage," as has already happened in hospital emergency procedure wait times.

Congress now understands that it has been warned. Even as it continued to increase benefits, several significant departments of the federal government warned Congress to act to get these promises under control. But Social Security and Medicare are the "third rails" of politics, and a powerful senior block of voters deterred politicians from addressing an honest downsizing of already bloated care packages. Medicare will survive, but only after serious and significant changes are made, and assuming that the nation's younger taxpayers accept the mortgage their

parents and grandparents have placed on their futures.