MEDICARE PRESCRIPTION BENEFIT / MEDICARE MODERNIZATION

ACT OF 2003

Health Policy – DHS 8090

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A course paper presented to the College of Allied Health

in partial fulfillment of the requirements for the

degree of Doctor of Health Science

Nova Southeastern University

February, 2011

Abstract of a report paper presented to Nova Southeastern University

in partial fulfillment of the requirements for the degree of

Doctor of Health Science

by

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February, 2011

 The Medicare Modernization Act of 2003 created the provision for a prescription drug benefit, known Medicare Part D. This benefit provided millions of beneficiaries with relief from high drug costs when the law took effect on January 1, 2006. While the federal government divested itself of the administration of this plan by offering it to private companies, cost containment remains a concern. Historically, and despite significant containment efforts, Medicare programs have found ways to increase in size and cost. What is on the horizon and what can we afford?

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INTRODUCTION

 The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was enacted under President Bush on December 8, 2003 (Medicare Modernization update overview, 2010). This act included an outpatient prescription drug program, known as Medicare Part D, which was implemented on January 1, 2006 (“Prescription drug coverage,” 2004; “Prescription drug coverage,” 2003). Medicare beneficiaries regardless of age, entitled to Part A or enrolled in Part B are eligible to enroll in Medicare Part D (“Prescription drug coverage,” 2003; “Prescription drug coverage,” 2004; Walker, 2011a). This voluntary drug benefit is delivered through private risk-bearing entities under contract with the Department of Health and Human Services. Drug benefits may be provided through prescription drug plans (PDP) or in comprehensive plans integrated with Part A and Part B benefits under the Medicare Advantage plan (“Prescription drug coverage,” 2003; “Prescription drug coverage,” 2004). Today, approximately 26 million Medicare beneficiaries are enrolled in the Part D prescription drug program (NCSL tools, 2011).

 The Congressional Budget Office (CBO) estimated direct federal spending for Medicare Part D would increase $410 billion from 2004 to 2013 (“Prescription drug coverage,” 2004). This includes the CBO estimate that Medicare Advantage provisions will increase direct spending by $14 billion during the same timeframe (“Prescription drug coverage,” 2004).

REVIEW OF LITERATURE

Summary of Policy

 The MMA created two major changes in the Medicare program. It expanded the role of private health care plans such as Medicare Advantage. However, it is better known for establishing a prescription drug plan also known as Medicare Part D for older Americans and persons with disabilities (Bodenheimer & Grumbach, 2009; Medicare Modernization update overview, 2010).

 Three years after its implementation, approximately 90% of Medicare beneficiaries have some type of drug coverage (Cubanski, 2009). Part D benefits cover drugs, biological products, vaccines, smoking cessation agents, and insulin (including medical supplies associated with injection) (“Prescription drug coverage,” 2004). Drugs excluded from this plan include drugs include those indicated for weight loss or gain, fertility, cosmetic or hair growth, cough or cold relief, vitamins and minerals, nonprescription drugs, barbiturates, and benzodiazepines (“Prescription drug coverage,” 2004).

 According to Bodenheimer and Grumbach (2009) the Medicare Part D program has its controversies. There are major gaps in coverage, some of which may be alleviated with the Affordable Care Act of 2010 (ACA). Coverage has been doled out to private insurance companies rather than administered by the federal Medicare program. Finally, the government may not negotiate with pharmaceutical companies to lower drug prices (Bodenheimer & Grumbach, 2009; Nogara, n.d.).

Background of Policy Development

 By 2000, prescription drug prices had steadily increased as new therapies became available. During this time, health care utilization shifted from hospitals to outpatient settings. Beneficiaries where having increasing difficulty paying for medications as Medicare only paid drugs administered during inpatient admission (Weissert & Weissert, 2006).

 As an indication of the need for the program, during its first year of operation, the Medicare Part D prescription drug program announced that more than 22 million beneficiaries were receiving prescription drug coverage through the program (DePue & Stubbings, 2008; NCSL tools, 2011). Additionally, in 2007, DePue and Stubbings (2008) state enrollment increased by another 7.6%.

 Before MMA, Medicare Part C, known as Medicare+Choice, allowed beneficiaries to elect coverage with private health insurers who would administer the Medicare benefit (Nogara, n.d). Similar in many regards to Medicare+Choice, MMA has replaced this with the Medicare Advantage plan. This also permits beneficiaries to elect coverage with private health insurers who administer Medicare benefits (Nogara, n.d). Although a Medicare Advantage plan may provide coverage for routine items that Medicare does not cover, it also has restrictions. The providers, prescriptions, and emergency treatment can be limited or restricted within a Medicare Advantage plan and beneficiaries are obligated to stay enrolled for a year according to Nogara (n.d).

Prescription Drug Plans in 2011

 During 2011, Medicare beneficiaries will have a choice of approximately 33 prescription drug plans (PDPs). This however, is substantially fewer choices offered nationwide than in any year since this drug benefit was implemented in 2006 (Hoadley, Cubanski, Hargrave, Summer, & Neuman, 2010). Hoadley et al., (2010) state the reduction of offerings (from 1,875 plans in 2007) is a result of regulations by the Centers for Medicare & Medicaid Services (CMS) to eliminate duplicate plan offerings and plans with low enrollment.

 In her article, Wagner (2011a) explains the significant differences among PDPs. Not all provide benefits for the same medications (Walker, 2011a). Some PDPs pay for certain types of medication or charge more for brand names versus generic drugs. Finally, monthly premium payments vary widely (Walker, 2011a).

 Rates have risen every year since the onset of the prescription drug plans in 2006 (Hoadley et al., 2010). Additionally, new income-related Part D premiums will take effect in 2011 for enrollees with annual incomes of at least $85,000 for an individual or $170,000 per married couple (Hoadley et al., 2010). Established by the ACA, higher-income enrollees will be required to pay a greater share of the standard Part D costs (Hoadley et al., 2010).

The Doughnut Hole

 The doughnut hole or the prescription drug coverage gap begins after the Medicare beneficiary incurs $2,840 in total drug costs. Beneficiaries then must spend up to $4,550 out of pocket on prescription medications before catastrophic coverage helps to contain prescription cost (Hoadley et al., 2010). Hoadley et al. (2010) add that most PDPs offer little or no “doughnut hole” or gap coverage. Once a beneficiary exceeded the initial coverage limit of $2,840, Part D benefits stopped even though it was necessary to continue paying premiums to keep the plan (Walker, 2011b).

 Under the ACA, one-time rebate checks of $250 are being mailed to qualifying beneficiaries as the first step in closing the prescription drug coverage gap created by Part D. The first round of checks was distributed in June of 2010. As Medicare recipients qualify and “fall into the doughnut hole,” they are sent the rebate check by Medicare (NCSL tools, 2011).

 As of 2011 and also the result of the ACA provisions, manufacturer prices for brand-name drugs purchased by beneficiaries while in the doughnut hole are discounted by 50%. Additionally, plans pay 7% of the cost of generic drugs while beneficiaries are in the Part D gap of prescription drug coverage (Hoadley et al., 2010). The ACA health reform law intends to gradually phase out the prescription drug coverage gap between 2011 and 2020 (Hoadley et al., 2010).

Low-income subsidies

 In 2007 annual incomes had to be below $14,700 for an individual or $19,800 for married couples to qualify for low-income subsidy (LIS) assistance. The subsidy and payments are based on a sliding scale according to income and assets (Kilian & Stubbings, 2007). Before the MMA was enacted, there were no provisions for premium and cost-sharing subsidies for individuals with low incomes (Nogara, n.d). Depending on the income and poverty levels, individuals may qualify for full drug benefit coverage with 100% subsidy for the deductible or commercial subsidies based upon income (Nogara, n.d). The eligibility for low-income subsidies is determined by state Medicaid programs or by the Social Security Administration with states receiving regular matching rates for associated administrative costs (“Prescription drug coverage,” 2003; “Prescription drug coverage,” 2004).

Projected costs

 Weissert and Weissert (2006) comment that the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 will start shifting more of the burden for Medicare cost to the beneficiaries. In the past Medicare has paid equally for all beneficiaries regardless of income or assets. Currently, means-testing consideration for all Medicare recipients is becoming relatively common and perhaps is inevitable if Medicare is to remain solvent (Weissert & Weissert, 2006).

 According to the 2010 annual report from the Social Security and Medicare boards of trustees, the outlook for Medicare has improved because of program changes made by the Patient Protection and Affordable Care Act of 2010 (ACA) (Status of the Social Security, 2010). The ACA is expected to reduce cost for the Medicare Supplementary Medical Insurance (SMI) program (Status of the Social Security, 2010). The SMI program will however, increasingly put pressure on the federal budget and beneficiaries in the upcoming years (Status of the Social Security, 2010). The cost for Social Security and Medicare programs are anticipated to rise steeply between 2015 and 2030 (Status of the Social Security, 2010). Over the next three decades, both Social Security and Medicare costs are projected to grow at a considerably faster rate than the economy (Status of the Social Security, 2010).

 The Congressional Budget Office 10 year estimate of $394.8 billion in spending takes into account the anticipated $409.8 billion of Medicare drug benefit, $14.2 billion for health plan reforms, among others and subtracts areas of anticipated savings including $21.5 billion for fee-for-service provisions and $13.3 billion for income related Part B premium increases (“Prescription drug coverage,” 2004). Meanwhile, the CMS estimates for 2004 to 2013 was $534 billion (Hunter, 2005). In February 2005, CMS updated an estimate for the ten-year period between 2006 and 2015 (two years later than the initial estimate) with a price tag of the drug provision to be $724 billion (Hunter, 2005). The cost estimate for 2004 to 2013 was understated, as the Part D drug entitlement program did not begin until 2006 (Hunter, 2005).

E-prescribing

 The MMA provided provisions to foster electronic prescribing (Bell & Friedman, 2005). Electronic prescribing systems (e-prescribing) have the potential to improve accuracy and efficiency of medication management. Bell and Friedman (2005) explain that e-prescribing aids in the accurate transmission of orders, helps avoid prescribing errors, and increases adherence to treatment guidelines.

 Some studies have shown an 86% decrease in serious medication errors and a significant increase in formulary adherence (Bell & Friedman, 2005). While these studies were mainly conducted in an acute care setting, there is potential for e-prescribing to improve medication management quality in outpatient settings. Other studies however, have shown an increase in medication errors largely because of human-machine interface issues and poor system integration (Bell & Friedman, 2005).

 The MMA requires that Part D plans support an electronic prescription program and makes available grants to physicians to assist in implementing electronic prescribing (Bell & Friedman, 2005). There is also a priority to assist implementation among rural physicians and those who serve underprivileged beneficiaries (Nogara, n.d).

Special Interest Groups

 Health providers, insurance companies, the pharmaceutical industry and retailers, and consumer groups were all involved in lobbying for the MMA in 2003 (Weissert & Weissert, 2006). Most notably, according to Weissert and Weissert (2006), the AARP and PhRMA played significant roles in the 2003 Medicare Modernization Act.

 Strongly endorsing the law, the AARP used the power of its membership to force Democrats to explain why they voted against the prescription drug bill (Weissert & Weissert, 2006). With its 35 million members, the AARP often takes a position on health issues and its endorsement is sought by both Democrats and Republicans (Weissert & Weissert, 2006). With offices in all 50 state capitals, the AARP are strong lobbyists (Weissert & Weissert, 2006). Interestingly, the AARP had previously opposed versions of the bill (Weissert & Weissert, 2006).

And the Winners are…

 Physicians receive a payment hike and are eligible for performance bonuses under a quality improvement provision included in MMA (Weissert & Weissert, 2006). Likewise, hospitals benefit from this bill as their lobbying efforts resulted in a 1.5% reimbursement increase in instead of the 4.5% decrease that would have been inflicted without the new law. Hospitals also receive a 4% increase in payments for every Medicare patient in exchange for voluntarily supplying quality assurance data to CMS. Furthermore, MMA prevents physicians from investing in specialty hospitals for 18 months while a study is conducted to determine the impact on patients in the Medicare program (Mechanic, Rogut, Colby, & Knickman, 2005; Weissert & Weissert, 2006).

 The drug companies were perhaps the biggest winners when the MMA bill passed (Weissert & Weissert, 2006). Pharmaceutical lobbyists managed to defeat government price setting for drugs, stymied reimportation, and weakened the state’s bargaining position for price negotiations (Weissert & Weissert, 2006). Through heavy lobbying and heavy-handed tactics by the Pharmaceutical Research and Manufacturers of America (PhRMA), the MMA took over the drug-program management, purchasing, and delivery responsibility for all Medicare beneficiaries (Weissert & Weissert, 2006).

 By supporting the passage of the MMA, Weissert and Weissert (2006) say the drug industry effectively stopped the states aggressive demands for price discounts as the MMA expressively forbids the federal government to set drug prices. Although the topic was fought and lost in court, PhRMA won the battle through Congress. Their efforts resulted in the states being forced to accept a new set of drug rules, choices, and the transaction cost of new drug vendors competing for Medicare beneficiaries business (Weissert & Weissert, 2006).

DISCUSSION

Financial Viability

 Despite being implemented slightly more than four years ago, there remain discrepancies and disagreements between CMS and the CBO about the cost of the Medicare Part D program and future projections (Hunter, 2005; “Prescription drug coverage,” 2004). A CBO 10-year estimate of $394.8 billion in direct spending is $139 billion less (nearly one third) than the CMS estimate of $534 billion for 2004 to 2013 (Hunter, 2005; “Prescription drug coverage,” 2004). When the first two years of this estimate are eliminated because the drug plan had not yet taken effect, the 10-year estimate nearly doubles the original CBO estimate to $724 billion (Hunter, 2005).

 There is further concern that once an entitlement program such Part D is in place, it becomes difficult to repeal or limit (Hunter, 2005). This bill is not self-financing; it is an open-ended entitlement largely paid for by taxpayers out of general revenues (Hunter, 2005). In comparison, the previous 1988 Medicare drug provision bill was designed to be self-financing. Nonetheless, its costs ballooned from $5.7 billion to $11.8 billion in just 12 months (Hunter, 2005; Medicare: A timeline, n.d.). The Medicare Catastrophic Coverage Act of 1988 was then repealed after little more than a year (Hunter, 2005; Medicare: A timeline, n.d.). Historically, and before the Part D implementation date, Hunter (2005) says, every proposed Medicare drug benefit has included a higher price tag than the one preceding it. The cost estimates of the Medicare Catastrophic Coverage Act of 1988 are microscopic to the obligations under the Part D of the MMA (Hunter, 2005).

 While plan sponsors negotiate drug prices with manufacturers and suppliers, the government may periodically audit sponsor financial statements to ensure proper disclosures and accounting (“Prescription drug coverage,” 2004). However, the government is prohibited from interfering with negotiations between drug manufacturers and pharmacies and may not require a particular formulary or price structure for reimbursement of covered drugs (“Prescription drug coverage,” 2004). If the past rapid rises in prescription drug prices are any indication, there is good reason to expect increases to continue. Already rates have risen for PDP premiums every year since the onset of Part D (Hoadley et al., 2010). Without government regulation, there appears to be little to prevent pharmaceutical companies from taking advantage of the situation. As higher costs are passed down to PDPs and Medicare Advantage plans, they will ultimately affect premiums and subsidies.

 This will contribute to the future escalation of costs for the Part D program. When added to the anticipated accelerated growth rate in Medicare over the next three decades and the increasing shift of the Medicare cost burden to the beneficiaries, the only remedy is significant rate increases to pay for the program. Unfortunately, this will also occur at a time of a very high retiree to worker ratio, putting a further burden on persons with fixed incomes.

 While Part D is expected to remain adequately financed, the ability of current law and Congress to automatically provide three quarters of the financing from general revenues each year will be an increasing challenge (Status of the Social Security, 2010). Any savings from the ACA changes to Part D are likely to be overwhelmed quickly by the anticipated 9.4% annual growth rate in Part D costs (Status of the Social Security, 2010). A Medicare public trustee estimated the Part D program would consume 25% of all federal income taxes by 2020 and expand to 50% by 2040 (Hunter, 2005). Meanwhile, Hunter (2005) calls the Medicare Part D program a massively expensive, open-ended entitlement that will cost more every year as costs soar (Hunter, 2005).

The Prescription Drug Coverage Gap

 The “doughnut hole” gap in drug coverage has been a source of discontent among Medicare Part D enrollees since its implementation. Unlike most Part D plans, the Affordable Care Act does provide some relief for those beneficiaries who have entered the $2,840 - $4,550 coverage gap by way of a rebate check and discounts for drugs (Hoadley et al., 2010). However, drug prices are negotiated with sponsors and are not regulated by the government. A 50% discount may actually result in less than a true 50% savings for the beneficiary. Should drug prices rise, this concept will likewise apply to the 7% of the cost of generic drugs paid by the prescription drug plans.

Enlisting Technology

 Utilizing technology to enhance drug management has been recognized as a potential method to provide efficient and effective drug management across multiple providers (Bell & Friedman, 2005). Sophisticated e-prescribing systems can provide physicians with information pertaining to lesser expensive drug options, drug incompatibilities, and best practice antibiotic selection (Bell & Friedman, 2005). With the national emphasis on electronic medical records that interface across a wide network of health care systems, e-prescribing aids in the goal of creating a comprehensive medical record that is accessible to a wide variety of medical providers.

 E-prescribing has the potential to provide cost-effective care through improved safety and efficient management of patient-specific medications. This certainly has application within a program designed to provide prescription drug coverage in the outpatient setting. As such, Bell and Friedman (2005) indicate pharmacists support e-prescribing within the Part D program. Additionally, improved drug management and intra-provider communication pertaining to patient-specific drug therapy may prevent hospital admissions resulting in further cost savings.

Maintaining Cost Control of Drugs

 As previously mentioned, the ability to control the cost of prescription drugs has been seriously impaired as the Part D law forbids government interference with price negotiations and may not require a particular formulary or price structure. This gives substantial price control of drugs to the pharmaceutical industry. The MMA also removed provisions to allow the import of less expensive prescription drugs from Canada (Mechanic et al., 2005). Ultimately, there is concern this legislation will not be effective cost control and guarantees future compromise and struggles over how to fund the Medicare program (Mechanic et al., 2005).

 In 2000, along with increased drug prices, health care moved from the hospitals, where Medicare did pay drug costs, to outpatient settings where Medicare did not cover the cost (Weissert & Weissert, 2006). Despite this higher drug cost burden borne by beneficiaries, the rate of Medicare payments continued to increase. Imagine what that increase would be like with more escalating drug costs.

 Part D appears to cover a reasonable array of drugs and biological products. This includes many preventative items including vaccines and prescription smoking cessation products (“Prescription drug coverage,” 2004). Excluded drugs are mainly those not necessary for health maintenance with the possible exception of vitamins for specific conditions or populations.

The Implications of the Upcoming Population Shift

 As the cost of prescription drug entitlement grows, so will the rest of Medicare (Hunter, 2005). This will further increase Medicare’s unfunded liability (Hunter, 2005). In 2004, the Social Security and Medicare trustees estimated the unfunded liability for Medicare over the next 75 years to be $27.7 trillion.

 The issue becomes more ominous when considering the ramifications of health issues of the upcoming elderly population. For example, Alzheimer’s disease is now considered a growing and major public health problem (Alzheimer’s Disease*,* n.d.). Researchers state that all models predict at least a threefold increase in the total number of persons with Alzheimer’s disease within the next 40 years (Alzheimer’s Disease*,* n.d.). The costs associated with care for the seven to ten years of dependency before death is $114.4 billion per year. This is expected to rise as an abundance of healthy, well nourished baby-boomers who develop Alzheimer’s live longer lives than their predecessors (Alzheimer’s Disease*,* n.d.). Consequentially, consideration needs to be given to the potential shift in health care services to skilled nursing centers and the shortage of health care workers.

CONCLUSION

 Medicare Part D, along with the changes the ACA is making to the gap in prescription drug coverage, is no doubt an enormous benefit for Medicare beneficiaries struggling to pay for medications. One will hopefully improve lives as a result. Nonetheless, future policymakers are going to be in non-stop conflict and turmoil trying to balance pressures to provide benefits to a growing AARP membership while necessarily limiting increases in federal outlays. Provisions within the Affordable Care Act may initially contain the financial drug burden for Medicare Part D beneficiaries, but it also results in a complex and expensive medical plan that has not achieved the goal of universal health coverage and may promote a significant rise in drug costs.

RECCOMMENDATIONS

 I am concerned the ACA benefits will continue as revenue producing parts of the law are eliminated. As such, I wonder why the doughnut hole remedy was activated before substantial financially supportive measures were implemented. Should the ACA be repealed, I am concerned as to how the Medicare Part D program will remain viable. However, as much as I likewise have financial concerns regarding the ACA, perhaps it is needed to keep Part D from bankrupting the country.

 Ultimately, I believe all this effort, while necessary, is misdirected. Instead, we must modify our views and accept the intent of health care as supporting the health maintenance efforts we should be practicing everyday. Health care should not be expected to act as a safety net to catch our non-compliance and repair our self-abuse. Efforts should be made to ban fast-food restaurants near schools, outlaw cigarette smoking except in private residences, charge an extra tax on food without a specified nutritional value, require parking to be further from college classrooms to promote walking, require physicians to provide information about safe exercise to seniors, and treat admissions to hospitals as a failure to keep the community healthy. Until then, throwing money at fixes just creates more problems requiring more money to fix.

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