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MED SUPP NEWS

SPECIALIZING IN MEDICARE SUPPLEMENTS, MEDICARE ADVANTAGE, & THE NEW MEDICARE PRESCRIPTION DRUG PROGRAM OR PART D

November 2007

Greetings and Thank You

Through the fall of 2007 things have been quite busy. I want to thank everyone that came on board in 2007.

2008 Medicare Changes

Medicare has publicized the annual increases for the deductibles and co-insurances. They are as follows:

	2007	2008
Part A deductible	$992	$1024
Days 61-90 hospital co-insurance	$248/d	$256/d
Lifetime Reserve days 91-150	$496/d	$512/d
Skilled nursing co-insurance	$124/d	$128/d
Annual Part B deductible	$131	$135
Your Medicare Part B Premium	$93.50	$96.40

Good news (for a change): Your Medicare Part B deductible has a very small increase this year.

Medicare Part B Means Testing

A year ago I wrote that the Medicare Part B premium will be means tested (people in upper income brackets will pay an increasingly higher premium. 2008 is the second year of the phase in.

Annual Election Period (AEP)

The Annual Election Period begins Nov 15, 2007 and ends December 31, 2007. First let's review the alphabet soup:

* **OM**: Original Medicare
* **PDP**: Stand-alone Prescription Drug Plan
* **MA**: Stand-alone Medicare Advantage Plan
* **MA-PD**: MA plan with an embedded PDP plan.
* **MSA**: Medical Savings Account. Note: This is a type of a Medicare Advantage plan.

During this 45-day period you can do the following:

1. Switch your PDP plan from one company to another.
2. Switch your MA plan to another company.
3. Switch from your MA plan to an MA-PD.*
3. Disenroll from your MA plan and return to OM.**
4. Switch from Original Medicare to an MA plan. ***
5. Switch from anything to an MSA plan. Note: If you are switching from an MA-PD, you will need to pick up a stand-alone PDP as the MSA plan does not have an embedded PDP.

* This will disenroll you from your existing PDP plan.
** You can pick up a Medicare supplement. You will have to medically qualify if you are out of the open enrollment.
*** You will terminate your Medicare supplement as it's of no use when you are on an MA plan.

There are some cautions to keep in mind. For example, if you have a Medicare supplement and a stand alone PDP plan and you enroll in a MA plan that has an embedded prescription benefit, you will automatically be disenrolled from your existing PDP plan. Likewise, if you enroll in an HMO or PPO MA plan, that will automatically disenroll you from your existing PDP, whether you do and don't take the embedded PDP option in the HMO or PPO MA plan. Sorry about the alphabet soup…saves space and more keyboarding.

Prescription Drug Plan News

I encourage you to have someone rerun your current Rx list on Medicare.gov to see which of the 50 some odd plans may be the best way for you to go in 2008. This is prudent for you to do so for the following reasons.

1. Your prescriptions (scripts) may have changed.
2. The PDP may have changed. **The plan that carried name brand drugs in the gap is going away**. A few plans will have *generic* only coverage in the gap for 2008.
4. Your existing plan may have switched one of your drugs to a different tier.
5. More generics are becoming available. Some plans work particularly better if you are on all generics as they have none or very minimal copays.
6. Some premiums have gone up. One popular one dropped!

The Gap and Catastrophic Levels. Some folks are understandably confused about what criteria puts them into the "gap" and what criteria puts them into the "catastrophic" levels. For 2008 the "Gap" level is $2,510. When your *retail total drug costs* reach $2,510 for 2008, you go into the gap. Let's say you are taking a 40mg Lipitor pill once per day. Your copay might be $25, but the retail cost is around $112 per month depending on the plan's negotiated retail price. Your copays for the year are $300 (12 months x $25), but your total drug cost is $1,344 (12 months x $112). You are halfway to the gap.

Let's say you are also taking Actos, for type II diabetes. Let's assume that your copay again is $25 per month. The retail cost of Actos is around $176 per month. That's $2,112 of total drug costs. Now you have $3,456 ($1,344 for Lipitor and $2,112 for Actos) of *total drug costs* and are well into the gap. Your coverage at this stage ends when you hit $2,510. You'll have hundreds of dollars of out-of-pocket with no coverage while in the gap.

Can you stay out of the gap? Not everyone can, but some people have found ingenious ways to reduce their likelihood of doing so. In the above example, if you can take a generic for Lipitor (consult with your doctor and pharmacist—they're a wealth of information)…lets say Simvastatin, then here is what happens. The retail cost ranges from $10-$20 per month. Let use $19. 12 months x $19 is $228 per year of **total drug costs**. Actos ($2,112) + Simvastatin ($228) = $2,340 of **total drug costs.** You stay out of the gap!

The *catastrophic* level in 2008 is when **your costs** (not total drug costs) hits $4,050. This means that when you have paid out of your pocket $4,050 for the calendar year, you now qualify for the *catastrophic* where you will pay about 5% of the costs of your prescriptions.

The Great Equalizer Resource: What is it? It's the *internet*, of course. If you don't have a computer, most local libraries do and are on the web. The librarians will be happy to assist you. Heretofore difficult to find information is now available to you with just a few clicks. Use the web as a tool to find out about any drugs you are taking. For example, let's say you are taking Fosamax. You can ***google*** the following: fosamax *benefits*, fosamax *side effects*, fosamax *generics*, fosamax dangers. fosamax alternatives. Put any script you are taking in front of the underlined categories. Become an expert. You have a powerful tool at your fingertips empowering you to become very knowledgeable about your medications. Learn as much as you can. .

WARNING: DO NOT MAKE ANY PRESCRIPTION CHANGE WITHOUT FIRST CONSULTING WITH YOUR PHYSICIAN. SELF-MEDICATING CAN BE DANGEROUS AND EVEN FATAL!

Staying out of the Gap
Things people have shared with me.

Disclaimer: I am providing this information for educational purposes only. Please consult with your physician or pharmacist with any questions concerning your scripts.

Here are some things that have come up in various conversations with clients concerning prescriptions. I have included some results from internet searches while I was on the phone with them. I have also referenced some things that I have come across. **Please remember the above warning**.

1. Sue (all names are assumed) told me that her doctor prescribed Benicar for lowering her blood pressure. Sue told me that she didn't like the side effects (dizziness) and wanted to do something about it. She went on a diet and shed many pounds. She told me that her doctor allowed her to lower her 40 mg dose by half and half again and half again down to 5mg. Eventually her doctor said she no longer needed the prescription. Sue's secret? Folks, this is revolutionary—she quit her pop and other sugary foods. Once she shed many pounds, she told me that she felt better and more full of energy than she had in years. Since Benicar retails for about $60 per month, she saved $720 (12 months x $60) in *total drug costs*.

2. Bill and Harold shared with me their use of *Red Rice Yeast*. Bill, not yet on Medicare, told me that his doctor wanted him to take a cholesterol lowering prescription but that he simply couldn't afford it. He found out about *Red Rice Yeast.* Yes, you can ***google*** that, too. Harold, close to 90, told me that he had been using *Red Rice Yeast* for years. He spoons a powder form into his cereal. **Check with your doctor!**

3. Alice called me one day extolling Dr. Robert Rowen's medical newsletter, *SECOND OPINION*. As I have been a student of health issues for over 35 years, I have just subscribed. I'll report more about this publication in my next issue. They're on the web at www.secondopinionnewsletter.com . Among other things, she explained to me that Dr. Rowen offers ideas as to how some people may be able to make lifestyle and dietary changes enabling them to reduce their prescription needs. Sue is a perfect case history.

4. I receive an email newsletter from David Eifrig Jr., M.D. I felt that one of his recent editions was so timely that I have reproduced it in its entirety in this newsletter. When you become a student of health issues and read and read, there is a recurring theme that occurs over and over: This is *elevated insulin levels*. This condition leads to all sorts of not-so good outcomes. What causes elevated insulin levels? Yes, come on, we all know the answer; it's those refined carbohydrates and especially the sugary treats that we love. Eliminate or drastically reduce these from your diet, and you will be much better off. Think you will switch to diet stuff containing aspartame or Splenda? Think again! ***Goggle*** "aspartame or nutrasweet dangers" and "Splenda dangers". Once you have a good understanding of what these artificial sweeteners are all about, you'll want to clean out your kitchen and throw that stuff away, and you'll no longer want to dump those little packets of chemicals into your coffee. I read about one study that essentially said that the use of the artificial sweeteners actually causes people *to gain weight*!

Splenda, or surcralose, was discovered by accident. Some researchers were experimenting with pesticides and one man from India, due to a language misunderstanding, inadvertently tasted one of their samples of chlorinated compounds. It tasted sweet. The rest is history.

5. I have a client, Jim, who is very internet savvy. He was buying Canadian prescriptions prior to 2006 and the advent of the PDPs. When he and I ran his meds on Medicare.gov, we saw that he went into the gap. Other than his Avandia (for type II diabetes) he was taking all generics. The Avandia, an expensive drug, is what kicked him into the gap. Jim explained to me that he had found a generic form of Avandia, made in India that is not available in the U.S., through his Canadian Rx plan at one third of the cost in the U.S. By removing Avandia from his Medicare.gov estimate, he stayed out of the gap. He still buys his generic Avandia from Canada.

6. Lois called me recently explaining the problem that she and her husband were having paying for Gleevec, used for treating leukemia. They can't afford the $2,600 per month. Yikes! I ***googled*** *generic gleevec* and discovered that a generic form is manufactured in India, but that Novartis (Gleevec's manufacturer) is in a legal dispute with the Indian government concerning patent infringement. The Indians seem to have a narrower definition of intellectual property. Their generic version runs about $160 per month! I was not able to ascertain if there was a generic form that someone can order. The gist of the whole thing is the Indians have sick people that need Gleevec but cannot afford $2,600 per month.

6. I had a very recent conversation with Joan who is struggling financially now that she is into the gap during the final months of the year. Others have also called me concerning the "gap". As I ran her meds on Medicare.gov to come up with a 2008 estimate for the most competitive plan, her annual cost will be around $3,200+. The biggest culprit in her line up of drugs is Actos. The retail cost of Actos is around $176 per month. That right there adds up to $2,112 of **total drugs costs!** While on the phone with her I ***googled*** "Indian generic actos". Was I surprised! There are several sites selling a generic *actos*, presumably manufactured in India. Some of the sites even had toll free phone numbers. The costs were about $2 per pill verses nearly $6 per pill at U.S. cost. If these sources are legitimate, acquiring her *generic* actos at one-third the retail cost keeps her out of the gap. Even by paying one-third of the cost outside of her PDP

plan as Jim does, she still saves about $900 per year. I reminded her to consult with her doctor first.

7. **BUYER BEWARE!** Betty called me asking if there is a generic form of Micardis. She's looking for ways to lower her husband's drug costs. I ***Googled*** Micardis and found that it is a hypertension drug in a class called *angiotensin receptor blockers*. Other well-known scripts on this class are Diovan, Benicar, Cozaar*, Avapro, and Atacand…all name brands. I told her to check with her pharmacist and doctor. Angiotensin is a compound that will naturally constrict one's blood vessels when needed, for example when exercising. I also spotted the following on blood-pressure.emedtv.com/micardis/generic-micardis.html . *Cozaar is now generic: Losarten

"Yet, if you search the Internet for "generic Micardis," you may find a number of companies selling it. The fact is, these medicines are fake, substandard, and potentially dangerous. You should not buy any generic Micardis until there is an approved generic version available." Scams are out there! Be careful!

Please send me any other helpful ideas that you have come across to lower your prescription costs and to stay out of the gap. I will publish them in my next issue.

Medicare Supplement Rate Increases

Some of your Medicare supplements have had rate increases. These increases vary from plan to plan and company to company. Some very competitive plans have come out in the market place in the past couple years. Once past 65 ½, you must *medically qualify* to apply for another company. Give me a call and let's see what we can do. In many cases switching from a Plan F to a Plan G can save you even more. Keep in mind that with Plan G you pay the annual Medicare Part B deductible.

Local Agents

The majority of "local" agents are doing a good job, however, there are still way too many that are selling over-priced plans to their people. Here are two examples. In one southern Idaho city an agent sold Margaret a $148 per month Plan F. More competitive plans range from about $102 to $110 per month. Not only did Margaret switch, but for even a better value she also went with a Plan G for around $82 per month. She'll save hundreds of dollars per year!

Karen: In a western Montana town, an agent, who sold her husband a Medicare supplement a few years ago, sold Karen a Plan F with the same company as her husband for about a $140 per month premium. She could have gotten the same Plan F for around $40-50 per month less. Understanding that she will pay her own Part B deductible, she ended up switching to a Plan G for around $58 per month less!

Both of these examples are an outrage, especially for people on tight budgets and fixed incomes. By the way, this is Mistake #7, *automatically* signing up with the same company that your spouse has.

Caution: Be very careful with **SCA**'s, or single company agents. Their Med Supps are usually overpriced.

Seminars: I urge the same caution here. The purpose of many seminars is to sell their Medicare Advantage plan. They rarely tell you about the disadvantages of their particular plan. If you attend such a seminar, ask them about the downsides and the "warts" of their plan. It may well be a good one for your situation, but again, ask questions!

More Election Periods

Note: These periods do not pertain to Medicare Supplements. Med Supps have a guarantee issue period up to 65 ½.

IEP: Initial Enrollment Period. This is a seven-month window to sign up for an MA plan or PDP. For example, you turn 65 in May. Your seven-month window looks like this:

(Feb. Mar, April **May-65** June July August)

OEP: Open Enrollment Period. This occurs from January 1st to March 31st.* You can change your medical plan during this period, that is, changing like for like.

1. You can disenroll from original Medicare and enroll in an MA plan.
2. You can switch from one MA plan to another.
3. You can disenroll from your MA plan and return to original Medicare.
4. You can switch from an MA-PD to another MA-PD.

Note: You cannot change from one PDP to another PDP.
*Discontinued in 2011.

SEP: Special election Period. You move out of your service area. Mary moves from California to Montana in August and leaves her HMO plan. She can sign up for an MA and PDP offered in her service area or county of residence.

OEP-New: You signed up for one MA plan during your IEP. You found another one you liked better. You may change.

Medical Savings Account (MSA) MA plan

During the course of the year I have spoken with various people better than 65 that showed an interest in the MSA plan. If you want to switch to this plan, you must do so during the AEP, and not the OEP. If interested, please indicate so on the check-off sheet. Look for the (MSA) line. *No longer available.

Please use the enclosed check-off sheet on page 4 to indicate areas of interest or changes you would like to make.

Coming up in the December issue of *Med Supp News…*

* I have come across a very promising **immunity boosting supplement**. Currently I am doing my due diligence and research concerning this product and will report further information in the next issue.
* I will discuss ecomomic issues such as inflation, Medicare, Social Security and how they will impact you in the future. Included in this is the huge problem of the unfunded liabilites of our Federal government. I will highlight the "*Fiscal Wake-Up*" article by David Williams, head of the GAO.
* Open forun—Let me know any topics on your mind.
* 2008 Calendars

Check with your doctor first!

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Syndrome X

August 05, 2007

Do You Have Syndrome X?
By Dr. David Eifrig Jr.

According to some estimates, one-third of all 55 year olds have Syndrome X.

By the time you get to 70 years, 50% of you will have it. And if you are younger, say 35-years-old… there's a 10% chance that you have it. The problem is that this syndrome may be deadly. And the name is mysterious because the diagnosis and prognosis are so unreliable. In fact, when you finish this article, you might roll your eyes and wonder why the hype. But, if you recognize that the factors that play a role in this syndrome are interconnected, you will easily understand the solution, and the cure will be critical to your long-term health and well being.

The good news is there are simple things that can be done; the bad news is that it will take some effort on your part. The worse news is that your doctor would prefer to give you pills rather than devote time and resources to curing this disease. Don't misunderstand me, I realize it's not a perfect world, but pills and injections are not the answer.

There are several symptoms consistent with this syndrome, which often appear hours after eating:

* Sleepiness
* Brain dysfunction (your memory and awareness are slowed)
* Blurred vision
* Sleep apnea
* High blood pressure
* High triglycerides
* Skin tags
* Increased weight
* Depression
* Intestinal distress (e.g. gas production)

Dr. Gerald Reaven at Stanford coined the term Syndrome X in 1988. He was researching diabetes and trying to understand the role of insulin in obesity, heart disease, and high blood pressure. It was clear to him almost 20 years ago that people with this syndrome (which is also known as Metabolic Syndrome, Reaven Syndrome, CHAOS, and Insulin Resistance Syndrome), had trouble processing glucose, which led to problems with insulin. Let me explain…

When we eat, especially carbohydrates, the body's chemicals break down the food into molecules that our cells use for energy – namely blood sugar, aka glucose.

The body notices this extra sugar and produces insulin in the pancreas. This insulin circulates in the blood and triggers a host of other processes. Without going into great detail, trust that the mechanism for glucose and insulin production was designed long before Twinkies…

The insulin binds to receptors on the surface of cells throughout the body. Cells have anywhere from 100 to 100,000 of these receptors, and very few cells have no insulin receptors. The fact that receptors are ubiquitous, and the levels of sugar and insulin vary so much, means that cells can alter their responses to these molecules. Therein lies the problem: The liver and the brain are intimately connected and influenced by glucose and insulin.

In fact, if you don't eat anything, the liver produces glucose for the rest of the body. And depending on the levels of sugar and insulin, the body will either store glucose (called glycogen) and moderate the burning of fat for energy or vice versa. On the other hand, the brain uses blood glucose to function and is dependent on a constant supply no matter what. I know I said I wasn't going into the details, but stay with me a little longer.

Insulin triggers a host of things, among those, a decrease of magnesium and an increase of sodium in the blood. Insulin also increases pro-inflammation molecules (like homocysteine) in the blood. It even causes the production of fat

and increases fat storage. This easily leads to increases in blood pressure and chronically can lead to a stroke and heart disease. And it gets worse…

Remember those insulin receptors? If our cells are bombarded with insulin, they decrease the receptors on the cell surface (wouldn't you?). Thus the body has to increase the amount of insulin to get the same effects on the cells. More insulin means more badness. Thus, if insulin levels are high, the body will never use fat… blood sugar is too high and the metabolism will be stuck in storage mode.

Thus the importance of avoiding foods that increase blood sugar, known as "high-glycemic index" foods. And the list of these foods is endless… Suffice it to say that whole grains and raw fruits and vegetables have a lower glycemic index than things like cookies or refined foods such as white bread and flour.

The bottom line is this: The human body needs glucose, fat, and protein. But anything that triggers increases in blood sugar – especially if it happens quickly and constantly – will lead to high insulin levels and thus insulin resistance (triggering Syndrome X).

From your and your doctor's point of view, the following traits are critical to diagnosing this syndrome:

* Abdominal obesity (men greater than 40 inches)
* Glucose intolerance
* High triglycerides
* Low HDL (this is the so-called good cholesterol)
* High blood pressure
* Insulin resistance
* Abnormally high insulin levels

There are simple tests you and your doctor can do. But if you have three of these symptoms, then you likely have Syndrome X. If you do have it, all is not lost. You can do two simple things to reverse the metabolic and structural problems.

1. **Avoid any food with the word sugar on the box**… This especially means the phrase "**high fructose corn syrup**."
2. After your biggest meal of the day, walk or exercise for 15-30 minutes.

When it comes to Syndrome X here's what I do:

* I try to exercise for 30 minutes at least five times a week. Moreover, I try to walk for 20-30 minutes after eating my evening meal.
* I try to eat foods higher in Omega 3 fats to balance Omega 6 (poly-unsaturated oils like corn, sunflower, safflower, and soybean) and Omega 9 (olive oil and many nuts). Recall that Omega 3s tend to be anti-inflammatory.
* I am trying to eat my last bit of food at least four hours before bed. That way, I can trick my body into thinking I'll need the energy and storing the glucose in my muscles as opposed to producing fat.
* I take vitamin C, E, and D to help keep my oxidant levels low and the fat in my body "healthy"… These fat-soluble vitamins play critical roles in the function of removing the oxidized products of living cells. This reduces the number of inflammatory molecules floating around in my body.
* I have reduced the sugar in my coffee to no more than one packet per day.
* **I have stopped drinking all soft drinks**, thus avoiding the high fructose corn syrup. (By the way, **diet drinks are no better**, because they trick your body into producing insulin anyway, which really messes things up since there is no sugar to act upon.) My note: There is a whole other issue concerning artificial sweeteners such as Splenda—not good.
* I try to eat **whole foods** whenever I can, including grains, raw fruits, and vegetables.
* I take 200mcg of chromium picolinate one to two times a week. There is evidence that this micronutrient helps with glucose and insulin regulation. There are also studies that show chromium decreases the amount of low-density cholesterol (LDL) the "bad cholesterol." (Red wine and broccoli are high in chromium.)

Until next time, be healthy.
David Eifrig Jr., M.D.