EXECUTIVE SUMMARY

President Bush believes the Nation has a moral obligation to fulfill Medicare's promise of health care security for America's seniors and people with disabilities. Medicare has provided this security to millions of Americans since 1965. However, as Medicare's lack of prescription drug coverage demonstrates, Medicare is not keeping up with the rapid advances in medical care. Medical care this century holds the promise of improving and extending life through countless innovations. To ensure that Medicare provides a secure entitlement for access to modern health care, for seniors today and tomorrow, the President is proposing a framework for improving and modernizing Medicare.

Medicare needs better benefits, including a prescription drug benefit, like modern health insurance plans. Medicare's outdated benefit package does not cover prescription drugs and does not provide timely, consistent coverage for many modern technologies and preventive treatments. It does not protect beneficiaries against the high costs of treating serious illnesses, and it imposes unnecessary regulatory burdens on providers and patients. As a result, seniors often do not receive appropriate, up-to-date treatment for their health problems. Most other insurance programs, including the program available to all Federal employees, provide reliable options for getting modern health insurance benefits. However, Medicare's options are actually becoming more limited.

The President believes that we must give seniors better options. He also believes that any improvements in Medicare should not force changes on today's seniors who are satisfied with their current coverage. In addition, any changes in Medicare must truly be improvements in Medicare's existing benefits.

Medicare is not financially secure for the retirement of the Baby Boom. The 77 million Americans who will be in Medicare by 2030 are counting on Medicare's promised benefits. Yet Medicare's fund for hospital insurance will face cash flow deficits beginning in 2016, and Medicare's fund for its other benefits will likely require a doubling of beneficiary premiums and of Medicare's claims on general revenues to remain solvent over the next 10 years. Medicare's bifurcated accounting disguises the true fiscal health of Medicare and makes it difficult to plan ahead.

President Bush has worked with members of Congress from both parties to develop a framework for a modernized Medicare program and for keeping Medicare's benefits secure. Modernized Medicare includes an improved traditional fee-for-service plan, and improved health insurance plan options. The President's framework for bipartisan legislation includes the following principles:

- **All seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare.**
- **Modernized Medicare should provide better coverage for preventive care and serious illnesses.**
- **Today's beneficiaries and those approaching retirement should have the option of keeping the traditional plan with no changes.**
- **Medicare should provide better health insurance options, like those available to all Federal employees.**
- **Medicare legislation should strengthen the program's long-term financial security.**
- **The management of the government Medicare plan should be strengthened so that it can provide better care for seniors.**
- **Medicare's regulations and administrative procedures should be updated and streamlined, while the instances of fraud and abuse should be reduced.**
- **Medicare should encourage high-quality health care for all seniors.**

21st Century Medicare

"When Medicare was passed in 1965, President Lyndon Johnson said: 'No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime.' Thirty-six years later, it is time for our Nation to come together and renew that commitment."

-- President George W. Bush

Medicare today provides health insurance to nearly 40 million people aged 65 and over as well as to people with long-term disabilities. For 36 years, Medicare has been immensely successful in fulfilling President Johnson's vision of helping seniors achieve the promise of a secure, vigorous retirement. Medicare has given over 90 million seniors access to many of the advances of modern medicine, which have helped them live longer and healthier lives. Medicare has also helped protect seniors from the higher costs of advanced care. But as we enter the 21st century, Medicare's promise is threatened by:

- outdated benefits that do not cover many valuable new technologies, including prescription drugs;
- limited financial protection for Medicare's covered services, forcing seniors to choose between increasingly costly supplemental insurance or the risk of impoverishment;
- a Medicare+Choice system that has not delivered the reliable health insurance options that have long been available to all Federal employees and most Americans under 65;
- a traditional government plan that often does not provide innovative care and that under current law cannot manage its benefits in an efficient way;
- a bureaucracy that often fails to deliver responsive services to beneficiaries and imposes unnecessary burdens on providers, because of excessively complex regulations and misdirected resources; and
- a Medicare program that often is not able to help seniors get the high-quality, error-free care they need or help health care providers deliver better care.

If we do not take steps to improve Medicare now, it may be unable to deliver on its promise of a secure and healthy retirement for today's and tomorrow's seniors:

- Based on its past record, Medicare's current benefits will have even more difficulty keeping up with the accelerating pace of medical innovation, including: individualized cures based on an understanding of each person's genetic and biochemical causes of a disease, microscopic devices that eliminate the need for unpleasant invasive treatments, and Internet-based and robotic therapies. All these innovations represent new classes of "medical services."

- Even Medicare's current benefits are not secure. Medicare's Part A (Hospital Insurance) costs will exceed its tax revenue after 2016, and Medicare's Part B (Supplementary Medical Insurance) Trust Fund is set up in a way that discourages planning ahead.

Failing to act to meet these unavoidable challenges may lead to more extreme changes later, including government controls on prescription drugs and stricter coverage limits in Medicare. These changes would reduce access to needed treatments and slow the development of new technologies, such as promising new drugs for Alzheimer's disease and common cancers. We must come together now to take the sound, careful, and deliberate steps needed to improve the Medicare program for today's and tomorrow's seniors. Thirty-six years from now, we should still have a Medicare program that fulfills President Johnson's promise of a secure and vibrant retirement.

Improving Medicare Benefits

"Medicare's current benefits were modeled on a good private insurance plan – from 36 years ago, in 1965. Back then, the primary concern was hospital costs. Today, many seniors are treated at home, or in a doctor's office, with drugs and new medical technologies. Back then, in 1965, the focus was acute care. Today, there is a greater emphasis on preventive care. Medicare is an enduring commitment of our country. It must be modernized for our times."

-- President George W. Bush

When Medicare was created in 1965, the benefit package was based on the most popular Blue Cross/Blue Shield insurance policy offered at the time. Since then, medicine has changed profoundly, and the health insurance options available to most Americans have changed along with it. Yet Medicare's benefit package has in many ways remained rooted in the 1960's. Medicare's coverage of many treatments is often delayed by years or even decades, as in the case of prescription drugs. Even when treatments are covered, Medicare's patchwork benefits have serious gaps, as too many seniors discover when they experience serious illnesses. These problems are illustrated not only by prescription drugs, but also by other types of care such as preventive medicine and treatments that provide alternatives to major surgery.

Prescription Drugs

One of the most glaring omissions in Medicare's benefits is the lack of prescription drug coverage. Prescription drugs are an increasingly important part of effective health care. They are used to relieve pain, enhance the lives of millions of Americans, and reduce health care costs by avoiding more costly treatments, hospitalizations, and complications. For example:

- Serious complications such as gastrointestinal bleeding and abdominal surgery for ulcers are becoming much less frequent because of drug treatment with a combination of antibiotics and proton pump inhibitor drugs. Innovative drugs can eliminate the cause of the vast majority of ulcers for less than $500, preventing prolonged hospitalizations costing upwards of $28,000.

- A year's worth of treatment with blood thinning drugs known as anticoagulants, which reduce strokes in patients with a common heart problem called atrial fibrillation, costs less than $1,000. In contrast, lifetime medical costs related to a serious stroke exceed $100,000.

- Drugs called statins can reduce heart attacks in older persons at risk and may reduce the risk of stroke and possibly other conditions, avoiding costly hospitalizations and many complications and deaths from cardiovascular disease.

- Drugs that promote calcium absorption into bones have been shown to significantly reduce serious complications of osteoporosis in older women, including the risk of hip fractures. Hip fractures often lead to long and costly hospitalizations, nursing home admissions, and even death.

In the past decade alone, almost 400 new drugs have been developed to fight cancer, heart disease, stroke, diabetes, Parkinson's disease, depression and arthritis. Thanks to active investment in research, still more effective prescription drugs are expected to reach seniors in the years ahead. These include treatments for a host of conditions ranging from breast and prostate cancer to Alzheimer's disease.

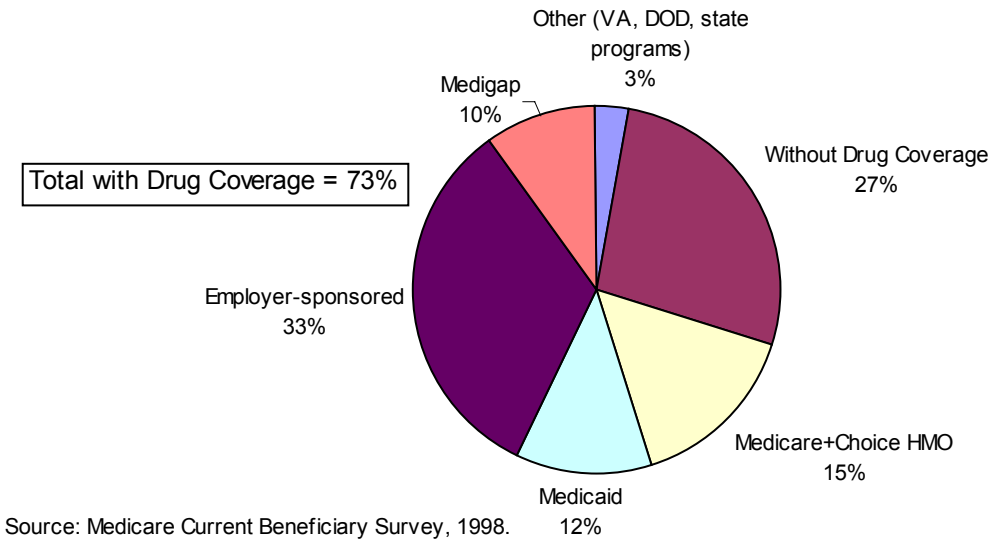
The vast majority of employer-sponsored health plans have long recognized the value of medicines in keeping people healthy and therefore provide drug coverage as part of their benefit package. Private plans began covering prescription drugs by the mid-1960s. Medicare's benefit package still has not been updated to include drugs, even though drugs are an increasingly important part of seniors' medical care. Nine out of ten Medicare beneficiaries will use at least one prescription drug this year, and the proportion who incur very high drug expenses is growing. As a result of the use of these valuable but costly new treatments, prescription drug spending is expected to continue to grow at the rate of 12.6 percent a year in the coming decade.

Without coverage from Medicare, most seniors have coverage from other sources (see Chart 1).

CHART 1

MOST SENIORS MUST GET DRUG COVERAGE OUTSIDE OF MEDICARE

PERCENT OF MEDICARE BENEFICIARIES WITH DRUG COVERAGE, BY SOURCE OF COVERAGE, 1998



Source: Medicare Current Beneficiary Survey, 1998.

Overall, about 27 percent of Medicare beneficiaries do not have prescription drug insurance and must pay for prescription drugs entirely out of their own pockets or go without needed drugs. Worse, this financial burden falls heaviest on those least able to afford it, and the impact on their health care may be significant. A recent study found that Medicare beneficiaries without prescription drug coverage used 8 fewer prescriptions a year than the seniors with coverage. The differences for low-income seniors were even greater – those without drug coverage used 14 fewer prescriptions than low-income seniors with coverage.

Quality private-sector prescription drug benefits not only protect seniors from the risk of high prescription drug expenses; they also help make all prescription drugs more affordable through innovative tools to help beneficiaries reduce their drug costs. Private insurance plans usually work with "pharmacy benefit managers" to provide these tools, which include:

- Competitive buying power to negotiate volume discounts: The benefit managers for large private insurance plans each represent many people who are likely to purchase drugs through their benefit. Thus, they can negotiate effectively to get the best drug prices.

- Assistance for seniors in choosing prescription drugs: By working with pharmacies and physicians to provide individualized information on more effective and lower-cost drug options, benefit managers can improve the quality of seniors' prescription drug use. Their computerized support systems can also help avoid adverse drug interactions, which are far more common in seniors than in any other part of the population.

According to a recent analysis by the Congressional Budget Office, these private-sector tools could save seniors significantly more than the savings that would be achieved through a government-run prescription drug plan. In addition, giving seniors a choice of options helps ensure that they will be able to use the drugs and pharmacies that they prefer.

Because a government-run plan will not be able to control drug costs as effectively, the higher prices would be likely to lead to permanent government price controls. In other industries where permanent price controls have been implemented, the result has been less supply and less innovation. President Bush believes that employing private sector tools can increase access to prescription drugs and encourage the development of even more valuable drugs in the future.

Preventive Care

Medicare's coverage of proven treatments for preventing illnesses and saving lives has also lagged. Coverage often comes long after preventive treatments are widely covered in private insurance plans. For example:

- Mammograms: Mammograms were first shown to save lives in the early 1980s by permitting breast cancer to be treated at a curable stage. Medicare did not cover annual mammograms until 1998.

- Prostate cancer screening: Tests were widely available in private health plans by the late 1980s. Medicare coverage did not begin until 2000.

- Flu vaccines: Flu vaccinations have been known to avoid serious complications from respiratory illnesses since the 1970s. Medicare did not begin coverage until 1993.

Even though these and other treatments such as colonoscopies and preventive care for diabetes have finally been covered, Medicare usually imposes significant copayments of 20 percent on the cost of preventive care. In addition, Medicare's coverage of many preventive services does not begin until beneficiaries have exceeded Medicare's $100 Part B deductible. As a result, healthy Medicare beneficiaries can face costs in the hundreds of dollars each year, just to keep up with recommended preventive treatments. Medicare's coverage of preventive care stands in contrast to the best private health insurance plans. Private plans have moved to a stronger emphasis on disease prevention by reducing beneficiary payments for preventive care, or even by making very cost-effective preventive services free.

Serious Illnesses

The development of new technologies and new treatments for the most serious illnesses, such as intensive life support for patients with major heart attacks, makes it possible for more people to survive potentially fatal illnesses. Unfortunately, Medicare beneficiaries who are sickest often pay the highest share of their health care costs – exactly the opposite of the way that logical insurance plans work. For example:

- Medicare's copayments for outpatient procedures related to serious illness, such as arthroscopic procedures on joints and complex chemotherapy treatments for cancer, may exceed 40 or 50 percent. Beneficiaries who have to undergo extensive or multiple outpatient procedures – such as cancer patients undergoing a course of treatment or diabetes patients who require multiple treatments for complications – may have thousands of dollars in Medicare cost-sharing obligations.

- People who require longer stays in skilled nursing facilities – for example, patients who have severe strokes or frail patients recovering from a hip fracture – face copayments of almost $100 per day.

- Individuals who need hospital care currently face a payment of almost $800 for each hospital spell. This payment is far higher than in virtually all private plans, which have a single deductible and a simpler copayment system. According to analyses by the Centers for Medicare and Medicaid Services, hospitalizations are common for Medicare beneficiaries. Even though less than one in five beneficiaries has a hospital stay in any one year, about half of beneficiaries require hospital care over a 5-year period, and about one in three beneficiaries have two or more hospitalizations. Medicare beneficiaries who require extremely long acute hospital stays are exposed to daily copayments that run into the hundreds of dollars, and Medicare coverage can eventually run out altogether. Medicare's coverage of hospital stays is far less generous than the standard Blue Cross/Blue Shield plan offered to all Federal employees (see Chart 2).

CHART 2

MEDICARE DOES NOT PROTECT AGAINST SERIOUS ILLNESS				
	Beneficiary Pays:			
	Days 1-60	**Days 61-90**	**Days 91-150**	**Over 150 days**
Medicare	$792 payment per hospital spell	$198 per day	$396 per day	All costs
Standard Blue Cross/ Blue Shield Plan for Federal Employees	$100 payment per hospital admission	$0 per day	$0 per day	$0 per day

These substantial cost-sharing requirements add up. Beneficiaries who incur costs of $25,000 or more are on average responsible for over $5,100 in cost-sharing due to Medicare's deductibles, copayments, and coverage limits. With modern technology, such costs are not that uncommon: the cost for treating a patient with heart disease who needs an implantable defibrillator exceeds $35,000. To protect beneficiaries when they need help the most, private insurance plans generally include stop-loss limits. Stop-loss limits provide guaranteed protection against very high medical expenses. Despite its important coverage, Medicare has no stop-loss protection.

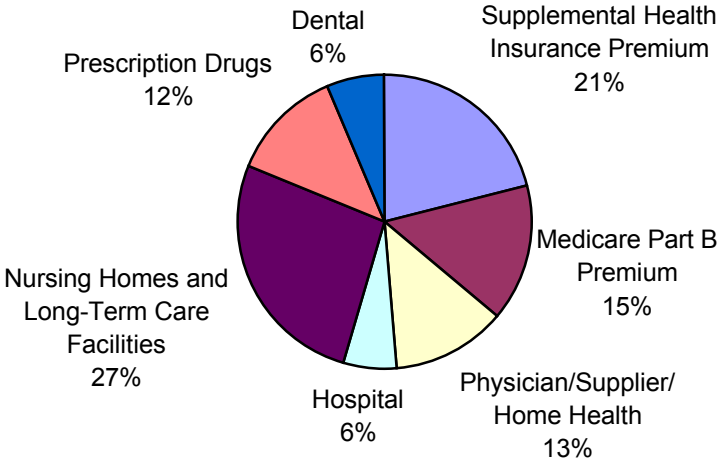
Supplemental Insurance

Because of the limitations in Medicare's benefit package outlined above, it is not surprising that six out of seven seniors in the traditional plan get supplemental or "wrap around" insurance to help fill Medicare's gaps. Some seniors get supplemental insurance from Medicaid, if their incomes are low enough. Others have employer-subsidized supplemental coverage as a retirement benefit. But a growing number of seniors do not have any of these options. They must either purchase individual supplemental insurance, called Medigap, risk burdening family and friends in the event of serious illness, or forego care altogether. Supplemental insurance is an essential part of the Medicare program. Supplemental insurance premiums now account for over one-fifth of beneficiaries' total payments for all types of medical care and exceed prescription drug and dental expenses combined (see Chart 3).

CHART 3

SUPPLEMENTAL INSURANCE PREMIUMS ARE A GROWING EXPENSE

MEDICARE RECIPIENTS SPEND $2,784/YR. OUT-OF-POCKET ON HEALTH CARE



Source: CMS Analysis of Medicare Current Beneficiary Survey (1998).

As seniors receive more treatments with high cost sharing, Medigap premiums have to go up. While the costs of the policies that provide some drug coverage have grown very rapidly, premiums for Medigap plans without drugs have also increased over the past 3 years – by 25 to 45 percent. By comparison, the Medicare Part B premium is both much lower than Medigap premiums and has increased by much less over the past 3 years – only 4 percent.

Because of the rising cost of current Medigap options, some seniors may prefer more affordable alternatives. Insurance experts who have analyzed the standard Medigap options have identified several components of the cost of supplemental insurance:

- Medigap coverage of the Medicare Part B deductible is "dollar trading," in the sense that beneficiaries pay for the amount of the deductible whether or not they get Medigap. Either they pay the first $100 of Medicare benefits, or they pay a premium for Medigap that is more than $100 higher than the premium for Medigap that does not cover the deductible. (The amount is over $100 because of loading costs for the Medigap companies.)

- "First-dollar" Medigap coverage also leads to higher Medicare and Medigap costs. Academic researchers and the nonpartisan Office of the Actuary estimate that service use is 23 percent higher for beneficiaries with Medigap than for beneficiaries without supplemental insurance. Medicare pays most of these costs, but they also lead to higher Medicare and Medigap premiums. According to the General Accounting Office, even modest changes in first-dollar coverage would lead to significantly lower Medicare costs, and in turn lower Medigap costs. The substantial budgetary costs of first-dollar coverage also contributes to the delays in covering new technologies in Medicare.

- The cost of covering Medicare's high payment for each hospitalization, and of providing protection against high out-of-pocket expenses, both contribute to rising Medigap premiums. Reducing the Part A hospital deductible and providing protection against very high expenses would result in more affordable Medigap options, because supplemental insurance would no longer have to cover these costs.

Almost all private insurance plans avoid first-dollar coverage and instead use reasonable copayments. Private plan enrollees have some limited out-of-pocket costs to help encourage appropriate use of services, and the enrollees benefit from much lower insurance premiums. Private insurance plans also take other effective steps to make sure that small copayments do not discourage appropriate care. These include providing extra incentives for patients and physicians to use preventive care that avoids complications, and implementing programs to encourage appropriate management of chronic illnesses.

The President's Framework for Improving Medicare Benefits

The President will work to improve Medicare benefits for all seniors based on the following principles:

Principle #1: *All seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare.*

Medicare's subsidized drug benefit should protect seniors against high drug expenses and should give seniors with limited means the additional assistance they need. The drug benefit should give all seniors the opportunity to choose among plans that use some or all of the tools widely used in private drug plans to lower drug costs and improve quality of care. The drug benefit should support and encourage the continuation of the effective prescription drug coverage now available to many seniors through retiree plans and private health insurance plans. The new drug benefit should also be available through Medigap plans and as a stand-alone drug plan for seniors who prefer these choices. When Medicare implements the drug benefit, states should not face maintenance of effort requirements for their own drug programs outside of Medicaid.

Principle #2: *Modernized Medicare should provide better coverage for preventive care and serious illnesses.*

Medicare's existing coverage should be improved so that its benefits provide better protection when serious illnesses occur and provide better coverage to help prevent serious illnesses.

- Medicare's preventive benefits should have zero copayments and should be excluded from the deductible.

- Medicare's traditional plan should have a single indexed deductible for Parts A and B to provide better protection from high expenses for all types of health care.

- Medicare should provide better coverage for serious illnesses, through lower copayments for hospitalizations, better coverage for very long acute hospital stays, simplified cost sharing for skilled nursing facility stays, and true stop-loss protection for Medicare-covered services.

These changes should not reduce the overall value of Medicare's existing benefits.

New Medigap options, which must be created for beneficiaries who choose the improved traditional plan with the new drug benefit, should give beneficiaries lower-cost options for reducing their out-of-pocket payments. These Medigap plans should begin by giving beneficiaries better protection against high expenses, and then should reduce Medicare's deductible and copayments.

Principle #3: *Today's beneficiaries and those approaching retirement should have the option of keeping the traditional plan with no changes.*

Many people in Medicare today, and others who are approaching retirement, have good supplemental coverage for prescription drugs and other medical expenses. If they wish to continue in the traditional Medicare plan with no changes in their premium, benefits, or supplemental coverage, they should be able to do so. Beneficiaries who opt for the improved Medicare benefits should be allowed for a year to switch back to the original plan.

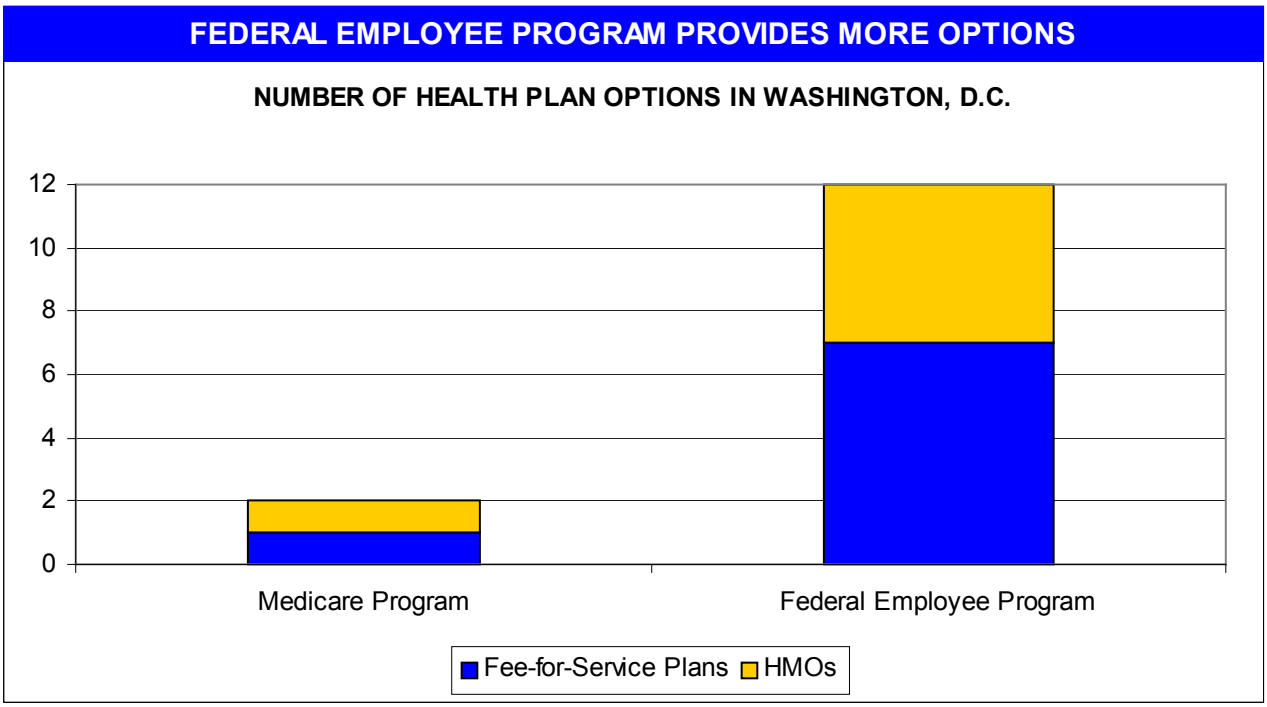
Providing Reliable Health Insurance Options for Seniors

> *"*Medicare beneficiaries should have the same kind of reliable coverage options available to all Federal employees throughout the country – a system that has been proven to provide one of the highest levels of satisfaction of any health care program in the country.*"*
>
> -- President George W. Bush

Medicare has lagged behind in providing reliable health insurance options that best meet beneficiaries' own circumstances and preferences. The Federal government, many state governments, and most large private employers help their employees get the care that is best suited to their needs by offering them several health care plans, along with unbiased and useful information to help them choose the best one. Medicare has failed to provide America's seniors with the same kind of reliable health care options that every Federal employee has received for decades. For many beneficiaries, particularly those in rural areas, Medicare offers only one health insurance plan – it is strictly one-size-fits-all. Previous legislation to address this problem, including the establishment of the Medicare+Choice program, has not had the intended effect of providing more reliable health insurance options for Medicare beneficiaries.

The effects of Medicare's current shortcomings can be seen very clearly in our Nation's capital. Federal employees and Members of Congress living in Washington have twelve different health plans to choose from, including a variety of fee-for-service plans, and health maintenance organizations (HMOs). But their neighbors with Medicare coverage have only two choices – the traditional fee-for-service plan and a single HMO (see Chart 4). This pattern occurs throughout the country. Park Rangers living in the most remote national forests, and postal workers in every neighborhood, have at least seven plan choices.

CHART 4



Private plans will be the best option for many seniors because:

- Private plans often provide innovative new health benefits – including preventive care, prescription drug coverage, and dental services – without having to wait for an act of Congress. Private plans also invented state-of-the-art coordinated care for the many Medicare beneficiaries who have multiple or chronic health problems.

- Private plan options allow seniors to reduce or eliminate their co-payments and deductibles so that their out-of-pocket payments are manageable.

- Private plan options give seniors more power. If they are not happy with the service they are receiving, they can simply switch to a different plan. Competition is the best way to make bureaucracies and health plans responsive – by giving customers the freedom to choose. Medicare beneficiaries should have the same options as working Americans.

Around one-third of seniors do not have access to any of these opportunities. And no seniors have access to new kinds of private insurance that have become popular with other Americans, such as "point of service" plans that give beneficiaries the cost savings of networks of providers along with the flexibility of coverage for services from all providers.

The President's Framework for Providing Reliable Health Insurance Options in Medicare

The President will work to provide seniors with more options for obtaining the medical care they want based on the following principle:

Principle #4: *Medicare should provide better health insurance options, like those available to all Federal employees.*

Medicare's coverage should be improved to give beneficiaries the same kind of reliable health care options that all Federal employees and many other Americans enjoy. As in the Federal employees' program and other successful programs:

- Plans should be allowed to bid to provide Medicare's required benefits at a competitive price, and beneficiaries who elect a less costly option should be able to keep most of the savings – so that a beneficiary may pay no premium at all.

- Medicare's payment system should create a level playing field for all plans in areas where private plans are paid less today and should continue to encourage private plans to participate in areas where Medicare provides few choices.

- The improved choice system should give beneficiaries useful and timely comparative information on the quality and total cost of all of their health care coverage options. Administrative burdens on private plans should be reduced while protecting patients' rights to allow good insurance plans to focus on providing reliable, high-quality service for Medicare beneficiaries.

- In areas where a significant share of seniors choose to get their benefits through private plans, the government's share of Medicare costs should eventually reflect the average cost of providing Medicare's required benefits in the private plans as well as the government plan. Low-income seniors should continue to receive more comprehensive support for their premiums and health care costs.

Keeping Medicare Benefits Secure for the Future

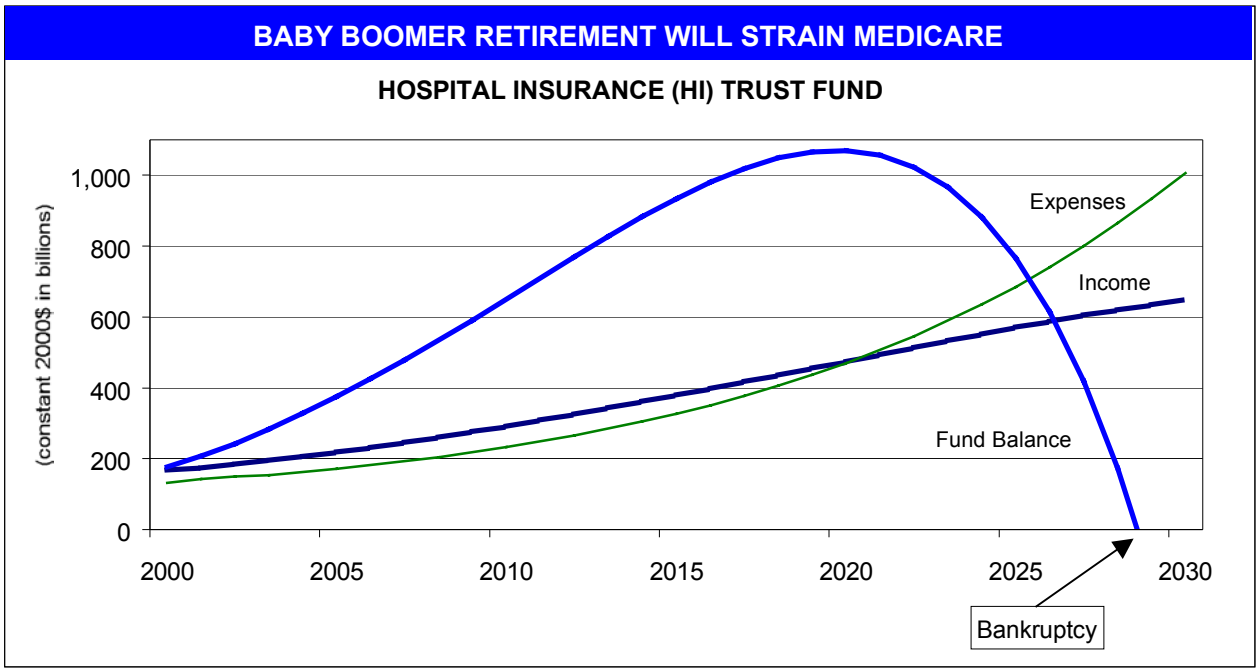
> *"Medicare has long-term financial problems – rooted in rising costs and an aging population – that threaten the security of its promised benefits just when the Baby Boom needs it the most."*
> -- President George W. Bush

Since 1965, Medicare has provided a guarantee of health care coverage for more than 90 million seniors and people with long-term disabilities. Medicare has made the same promise to millions of Americans who are contributing their hard-earned dollars through payroll and income taxes. These Americans are counting on the financial stability and integrity of the Medicare program.

Despite the importance of Medicare's promised benefits to all Americans, Medicare's bifurcated trust fund system does not provide a clear picture of Medicare's financial status. The best-known measure of Medicare's solvency looks at only half of the program – the Hospital Insurance Trust Fund (HI) or

Part A. This trust fund finances hospital services and "post-acute" services after hospitalization, but does not account for spending on physician and outpatient services. These services represent nearly half of all spending and are growing at a faster rate than inpatient services. Even when using this narrow approach, by 2016 Medicare is projected to have Part A expenses that exceed its new revenues (excluding interest income), and then to head rapidly toward bankruptcy by 2029 (see Chart 5).

CHART 5



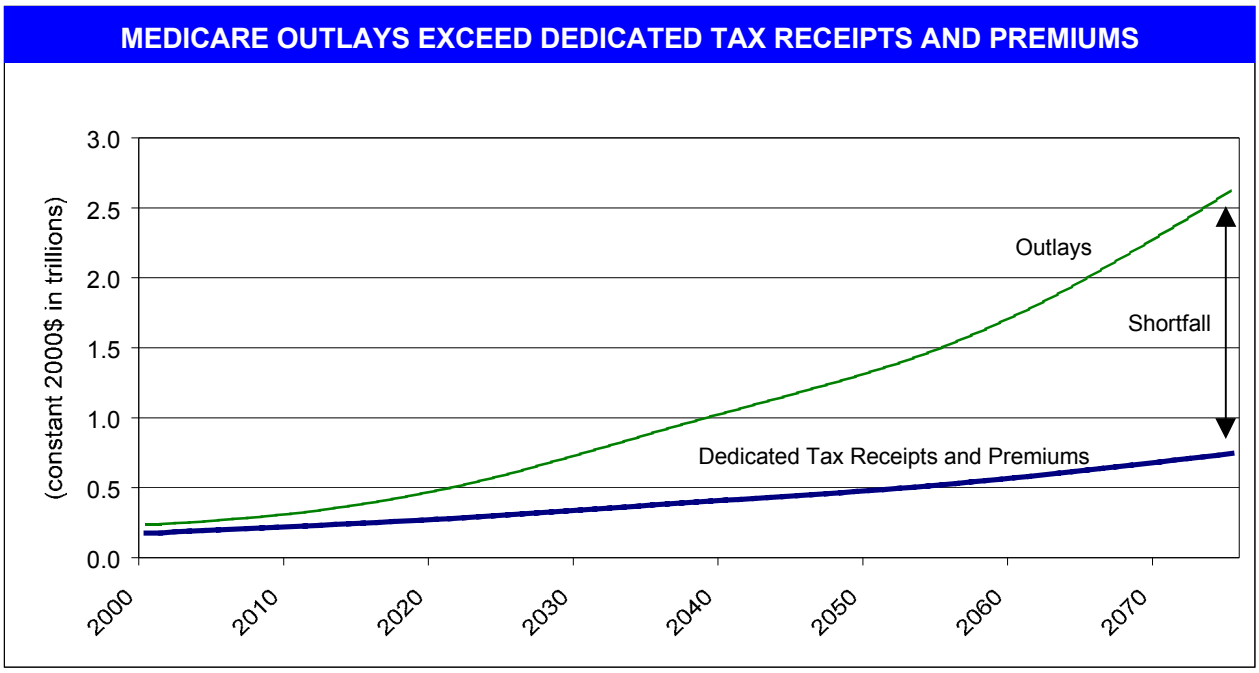
Medicare's trust fund for the other half of the program, the Part B or Supplementary Medical Insurance Trust Fund, is financed mainly from income taxes and partly from beneficiary premiums. Part B's expenses are projected to rise even more rapidly than Part A expenses. However, because income tax contributions and beneficiary premiums are increased automatically as Part B costs rise, the Part B Trust Fund will not become insolvent. This does not mean that Part B benefits are secure from a budget standpoint – as the income tax contributions keep rising, it will be more and more difficult for taxpayers to sustain the total cost of the Medicare program and other important national priorities.

Between now and 2030 the number of persons age 65 and older is expected to increase rapidly from 40 million to 77 million. Since Medicare relies primarily on payroll and income taxes to finance its benefits, this increase means that the payroll taxes of fewer workers will be available to support the benefits of more retirees. Expenses will also rise because health care costs are expected to increase.

The importance of meeting Medicare's benefit guarantee despite the rising costs facing the program means that careful financial planning is essential. Careful planning requires viewing Medicare's finances in their entirety, including both Part A and Part B benefits, to have an accurate and straightforward picture of the program's overall financial outlook. A comparison of Medicare's dedicated revenues and premiums to total spending reveals an imbalance -- spending far outpaces dedicated dollars coming into Medicare from payroll taxes and premiums (see Chart 6). Medicare is kept solvent by an increasing claim on general fund revenues. This revenue requirement is projected

to more than double over the next 10 years. And even with this large infusion of revenues, Medicare will still go bankrupt in 2029. In addition, total Medicare expenditures are expected to consume an ever growing portion of the US economy, rising from 2 percent of GDP today to almost 9 percent in 2075, or about half the size of the entire Federal government now. This amount also exceeds what the Federal government spends now on all discretionary Federal programs – education, defense, crime, and others. Only by planning ahead can drastic, undesirable changes in Medicare or other Federal programs be avoided.

CHART 6



The President's Framework for Keeping Medicare's Benefits Secure

The President will work to strengthen Medicare's benefit guarantee based on the following principle:

Principle #5: *Medicare legislation should strengthen the program's long-term financial security.*

Legislation should strengthen Medicare's ability to plan for and provide its benefit entitlement in the years ahead, thereby improving the program's long-term financial security. To support good planning for the entire program, Medicare's separate trust funds should be unified to provide a straightforward and meaningful measure of Medicare's overall financial security that is not vulnerable to accounting gimmicks. Financial security cannot be achieved simply by increasing reliance on unspecified financing sources.

Improving the Management of the Traditional Medicare Plan to Provide Better Care

Medicare's traditional plan is falling short in important respects other than its benefits. It has not been able to use competitive approaches to help keep its costs down. Its contracting requirements are outdated, making it more difficult for providers and patients to work effectively with a complex claims processing system. And perhaps most importantly, the government plan does not provide efficient, integrated services for many seniors who need support for managing their illnesses, particularly in cases of chronic disease.

Higher Cost

Enrollees in traditional Medicare frequently require the use of medical supplies such as hospital beds, blood glucose monitors, wheelchairs, and oxygen equipment. Under current law, Medicare sets regulated prices for literally hundreds of these supplies. These prices set by Medicare tend to be higher than those paid by private plans or even other government agencies that negotiate or contract for the same supplies on a competitive basis. A number of studies and recent Medicare pilot programs indicate that the cost of supplies could be reduced by between 15 and 30 percent if the traditional plan used the same kinds of competitive bidding tools that help reduce costs and improve quality for non-Medicare patients.

Outdated Contracting Authority

Medicare's current contract authority has also failed to keep pace with changes in the health care industry. For example, Medicare is restricted to using certain insurance companies to process certain types of claims. Other businesses have the expertise and capacity to provide these claims processing services, but Medicare is prohibited from contracting with them. In addition, unlike other purchasers, Medicare cannot reward or penalize a contractor based on their performance, regardless of error rates, delays, and responsiveness to providers and beneficiaries.

Limited Access to Innovative Treatment

Many Medicare beneficiaries are among the sickest and most vulnerable individuals in our society, with complex chronic and acute medical conditions. Unfortunately, Medicare's traditional approach to paying only for discrete visits and services has denied many seniors the opportunity to take advantage of the advances that have been pioneered by integrated health plans in coordinating care for complex conditions and chronic diseases. These programs can lead to better health outcomes and reduce total medical costs by avoiding complications.

For example, over 30 percent of the elderly suffer from some form of heart disease – a condition ideally suited to integrated medical management, including diet, exercise, smoking cessation, and medication counseling. Each of these steps has been proven to reduce the risk of further cardiovascular complications, and programs developed by health plans that use integrated, coordinated approaches featuring experienced professionals have been shown to achieve better results in all dimensions. Many individuals with heart disease who are enrolled in private plans can take advantage of these kinds of integrated programs, while traditional Medicare enrollees cannot. Similar private programs have also been developed by integrated health plans for individuals with diabetes (afflicting 13 percent of seniors), hypertension (afflicting 40 percent of seniors), and HIV/AIDS. Altogether,

over two thirds of seniors could benefit from the kinds of integrated clinical management programs common in private plans and widely available to non-Medicare beneficiaries.

The President's Framework for Improving the Management of the Government Plan

The President will work to improve Medicare based on the following principle:

Principle #6: *The management of the government Medicare plan should be strengthened so that it can provide better care for seniors.*

The management of Medicare's government plan should be updated and improved, to provide lower-cost and higher-quality care for seniors who prefer this plan.

- Medicare should be allowed to use competitive bidding tools to improve quality and reduce costs for durable medical equipment, prosthetics and orthotics, and clinical lab services – provided that the government plan is not allowed to create new price controls and that seniors continue to have choices.

- Contractor reform should be implemented to improve efficiency and performance.

- Beneficiaries who wish to participate in innovative programs such as disease management should be able to do so through expanded demonstration authority to implement promising new initiatives that have local support.

- Medicare's process for covering new technologies should be streamlined.

Reducing Bureaucratic Complexity, Fraud, and Abuse

Medicare today is a complex system of ever-changing rules and regulations affecting the 40 million Medicare beneficiaries and over 1 million physicians and providers who serve them. Patients and providers face variable and inconsistent policy interpretations from various contractors and from different offices with overlapping jurisdictions within the Federal government itself: Rules may vary across areas and over time. Beneficiaries and their families may find the system confusing and difficult to navigate. Providers seeking technical assistance from Medicare are often frustrated because their questions go unanswered.

Nonetheless, providers are expected to comply with a near-continuous stream of complicated regulations and program changes. Providers are forced to spend more time and effort keeping up with the latest rules and interpretations instead of providing patient care. Even worse, some physicians have stopped treating Medicare patients, and more are threatening to do so.

The complexity of Medicare makes targeting fraudulent activities difficult without unfairly burdening the vast majority of honest physicians and other providers. Providers who are struggling to give Medicare beneficiaries the best care that they can, while also struggling to avoid billing errors, are laboring under the misperception that honest errors might be considered fraud. At the same time, the magnitude of improper payments is a serious problem for taxpayers. The Office of the Inspector

General found that Medicare made $11.9 billion in improper payments in 2000. This amount would be sufficient to increase the entire budget of the National Institutes of Health by two-thirds. It is a significant reduction from earlier years, but also a clear indication that more needs to be done.

Complexity, variability, constant change, and the existence of some rules that just are not workable when a doctor is caring for a patient all contribute to the need to reduce regulatory and administrative burdens in Medicare. As Dr. Robert Waller, Chairman Emeritus of the Mayo Foundation, has testified, "The public has been led to believe that the Medicare program is riddled with fraud, when, in reality, complexity is the true root of the problem."

Medicare's administrative structure also contributes to this complexity. The current administrative agency with responsibility for running the traditional plan, the Centers for Medicare and Medicaid Services, must also manage private plans and Medicaid. Currently, the same administrators running the traditional plan must also oversee competing private plans – even though these tasks often require different skills. The traditional plan deserves its own dedicated administrators focused on making the plan operate more effectively. Medicare's program-wide responsibilities, including oversight of private plans and providing good information on coverage options to beneficiaries, also deserve specialized administrators. Separate specialized teams will also help protect against conflicts of interest, and provide clearer lines of communication for beneficiaries and providers.

The President's Framework for Reducing Bureaucratic Complexity, Fraud, and Abuse

The President will work to improve the administration of the Medicare program based on the following principle:

Principle #7: *Medicare's regulations and administrative procedures should be updated and streamlined, while the instances of fraud and abuse should be reduced.*

Needed relief in regulation and oversight, including some bipartisan proposals from members of Congress, should be implemented. This will allow providers to spend more time and effort on patient care and less on paperwork and unexpected and complex rule changes, while continuing to assure the integrity of Medicare funds. Medicare's administration should be restructured so that program staff can work more effectively with beneficiaries, health care providers, and health plans.

Higher Quality Care for Medicare Beneficiaries

The President believes that Medicare's most important goal is to enable our Nation's seniors and disabled Americans to get the high-quality, error-free health care they deserve. Physicians and other health care providers unquestionably share this goal. Unfortunately, the Medicare program today is not creating an environment for medical practice that encourages and supports high-quality care that can improve health and reduce costs. Failures to provide recommended treatments, as well as frequent medical errors with serious consequences for seniors, potentially account for a large share of Medicare expenses and present an opportunity for making Medicare beneficiaries and taxpayers better off.

There are many examples of failures to provide high-quality care in Medicare:

- A recent study published in the prestigious Journal of the American Medical Association found that treatment of Medicare patients with heart attacks varies widely. For example, while it is recommended that patients take aspirin within 24 hours after their heart attack, the proportion of patients who actually received this treatment ranged from 75 percent in one area of the country to 97 percent in another area.

- A recent study showed that only 69 percent of Medicare beneficiaries with diabetes received recommended eye exams to determine if treatment was needed to prevent blindness. And only 71 percent of beneficiaries with diabetes received a test to determine whether their blood sugar was in control to determine if their medications needed adjusting.

- Only about 55 percent of women in the government plan who were less than 70 years old received the annual mammogram that has long been recommended as a critical part of early breast cancer detection. One out of eight women will develop breast cancer over her lifetime. When detected early, the chance that breast cancer can be cured is much higher – the vast majority of patients with the disease can survive it.

Some quality problems may be greater in rural areas. For example, hospitalization rates are higher in rural areas for some chronic conditions, like angina and chronic pulmonary disease, that can usually be treated effectively outside the hospital. Rural beneficiaries are also less likely to get mammograms and recommended follow-up visits after a hospitalization.

The problems of benefit gaps, lack of coverage options, outdated management practices, and excessively complex administrative burdens undoubtedly contribute to these results. There is also increasing evidence that a range of private sector and public-private initiatives can help providers deliver better and safer care. For example, many hospitals and other health care institutions have launched collaborative efforts to use information related to quality, giving providers and patients more useful information while reducing the burden of data collection. Some health insurance systems have implemented payment incentives to encourage and reward better performance. Many of these initiatives may be particularly challenging for rural providers. For example, investments in new information systems or hiring specialized personnel may be very difficult for rural facilities with limited scopes of service and small patient volumes.

The President's Framework for Improving Quality of Care in Medicare

The President will work to improve the quality of care based on the following principle:

Principle #8: *Medicare should encourage high-quality health care for all seniors.*

All Medicare beneficiaries deserve high-quality, error-free care. To assure that beneficiaries get the most from Medicare's improved benefits and coverage options:

- Medicare should support efforts by plans and providers to improve care through more collaborative programs that use protected data on quality and safety. Medicare should help seniors get better care through improved information on quality.

- Medicare's payment system in the government plan should take steps toward rewarding better performance and encouraging investments that improve quality of care without increasing budgetary costs. Medicare's risk adjustment system for private plans should reward health plans for providing appropriate care and reducing complications for chronically ill, high-cost patients without creating costly reporting burdens.

- Medicare should address the additional challenges facing rural health care providers in delivering high-quality care.