National Committee to Preserve Social Security and Medicare
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SUMMARY: THE NEW MEDICARE LAW

For more than 38 years now, the Medicare program has successfully provided basic, nearly universal health coverage to America's older and disabled citizens. This success derives from its social insurance model under which nearly all working Americans and all beneficiaries contribute toward a national pool that shares both risks and resources. That is why Medicare can provide a guaranteed standard of health care to our nation's highest consumers of care at an administrative cost far lower than most options that exist for younger and healthier Americans today.

For their health care needs, prior to 1965 seniors were essentially on their own. Older Americans are virtually guaranteed to draw higher health claims than any other segment of our population and were, for the most part, shunned by private health plans. About half of all seniors in 1965 had no health insurance and nearly 35 percent lived in poverty. Though the nature of health delivery has changed dramatically since 1965, basic economic and social realities confronting seniors and private health markets have not.

The Medicare Prescription Drug Improvement and Modernization Act begins a journey, not forward, but backward in time, to the way things were before 1965. The new law begins the segmentation of the strong national risk pool of over 40 million individuals, into smaller regional groups. The law will begin immediately to provide subsidies beyond what traditional Medicare pays to convince private companies to offer a complex array of plans to seniors whose benefits and costs are not specified in the law. While supporters of the new law claim seniors will still have the option to remain in the defined benefit traditional Medicare -- the plan that offers near absolute choice of doctors and hospitals -- fee-for-service Medicare is disadvantaged in many ways. This is part of a deliberate effort to draw or even force seniors out of Parts A and B, and to end Medicare, as we know it.

The National Committee to Preserve Social Security and Medicare remains committed to the principle that traditional, fee-for service Medicare, with its structure of benefits and beneficiary responsibilities that are specifically defined in law, must remain a viable option for all seniors who choose it. We will dedicate our efforts to restore the equity between private plan options and traditional Medicare that has been undermined in various ways within the new law.

Though it will not begin until 2006, the new drug benefit is a welcome addition to Medicare for those it does help. For many low-income seniors, it is an improvement. Still the net gain remains uncertain, as benefits, costs, and access are not guaranteed in the law. The benefit has a complex and confusing structure, containing provisions such as holes in coverage and private, prescription drug-only plans, many of which do not exist in private health markets today.

The attached summary is designed to respond to the many questions being asked about the new law. Undoubtedly, due to the uncharted direction and unusual structure of the new provisions, more questions will continue to be raised for the foreseeable future.

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PRESCRIPTION	▪ Starting in May 2004, seniors will be allowed to purchase a "Medicare approved" drug discount	▪ The discount cards will not be available through the Medicare program, only though the private

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DRUG DISCOUNT CARD	card from a private company. The discount cards will only be available until the new prescription drug benefit becomes available in January, 2006. The cost of the card cannot be higher than $30 per year. ▪ Private companies who wish to offer the cards will submit bids to the Department of Health and Human Services. To qualify, the companies will need to meet certain requirements, including signing up a large network of pharmacies. Beneficiaries will have at least two cards to choose from, but may only sign up for one at any given time. Changing from one card to another will only be allowed during specified open periods, and the first one will be between November 15, 2004 and December 31, 2004. ▪ There is no minimum discount that the cards are required to provide. The administration estimates the average senior will save between 10% and 15% off their total drug spending. ▪ There is no requirement that all Medicare eligible drugs be covered by the card. Companies may change which drugs are covered and how big a discount they provide at any time. Cardholders are not required to be notified except by posting on the Internet. ▪ Seniors with annual incomes less than 135% of the federal poverty line ($12,569 for singles and $16,862 for couples in 2004) will be given $600 already credited on the cards to spend on medications. ▪ Low-income seniors below 100% of the federal poverty line ($9,309 for individuals, $12,489 for couples in 2004) will be limited to a 5% co-payment on drugs purchased through the discount cards; seniors below 135% of poverty ($12,569 for individuals and $16,862 for couples in 2004) will be limited to a 10% co-payment.	companies administering the cards. This begins the trend of placing the traditional Medicare program in the hands of private companies. ▪ In areas with multiple companies offering the discount cards, they could get very complicated to use because each company offering a card will have a different list of covered drugs (the formulary) and a different amount of discount on each drug on the list. Once a senior selects a card, he/she is allowed to change their cards only once later that year. The drug companies, on the other hand, will be allowed to change which drugs are on their lists and the prices on the drugs on that list on a weekly basis. The only notification of changes that is required to be given to cardholders is by posting them on the Internet, which few seniors use regularly. ▪ To get the maximum advantage from the cards, seniors will need to inventory the drugs they take, compare their costs with the "sample" price lists available from the companies, and then determine which card and which company best suits their needs. However, if the drugs they are required to take change after they have selected a particular company's card, or if the company offering the card changes the discount amount on the drugs they take, seniors could be subject to unexpected costs. ▪ The administration is estimating that the cost savings will be between 10% and 25% off the retail price of prescriptions, but there's nothing in the bill that requires ANY specific amount of discount, or that keeps the retail price of the drugs from increasing to compensate for any discount. The bill itself doesn't even require that the full amount of any discount negotiated between the companies offering the cards and the pharmaceutical companies be passed along to seniors. All the bill says is that government "expects a substantial share" of any discounts will be passed along to seniors. The only requirement in the bill is that at least one drug in each drug category offered be discounted. Depending on the combination of drugs used by a particular senior, they may or may not have any significant savings. ▪ It's not clear how many pharmacies would honor the new cards. If previous experience is any indication, large chain-stores would be more

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		likely than the smaller, closely-held stores to honor the cards. This would make the cards less available in rural areas or low-income urban centers. ▪ Some pharmaceutical companies and other groups (such as AARP, Reader's Digest, Costco etc.) already offer discount cards to seniors. It is unclear what would happen to these existing programs, though it can be assumed that some companies would discontinue their own programs and either participate in the federal program instead, or stop offering the discount programs altogether. If enough companies do this, seniors will have no more options than they have today for reducing the price of drugs, and they could well end up with fewer choices. ▪ Low-income seniors are to be given a $600 credit balance on their cards. It is not clear how the administration intends to provide the private card providers with enough income data on eligible seniors to allow the cards to be appropriately credited. If state Medicaid programs administer this benefit, which is likely, seniors will be subject to the variability in quality and accuracy currently evident in state Medicaid programs.
PRESCRIPTION DRUG BENEFIT	▪ On January 1, 2006, a new, voluntary prescription drug benefit will become available as Part D of Medicare. Beneficiaries will be able to purchase either "standard coverage" or alternative coverage with "actuarially equivalent" benefits. The new benefit will be offered through private companies, not through the traditional Medicare program itself. ▪ The new prescription drug benefit will not be available through traditional Medicare. In most areas, a drug benefit will only be available through private companies, either as a stand-alone benefit or as part of a broader health package (e.g., through an HMO or PPO). At least one stand-alone plan and one "full-service" plan (HMO or PPO) must be available in each area – if they're not, a government sponsored fallback plan will be established, financed by the federal government but administered through private companies. ▪ In 2006, "standard coverage" will have a $250 deductible, and a premium estimated to be about	▪ Because the traditional fee-for-service Medicare program will not be permitted to offer prescription drug coverage (except as a fallback), it will permanently be placed at a disadvantage when seniors compare it to private health plans (e.g., HMOs and PPOs). This helps erode support for traditional fee-for-service (FFS) Medicare and pushes seniors into private managed care plans, even if they would prefer to stay in traditional FFS Medicare. The subsidies that will be given to the private companies as incentives to participate in Medicare exacerbate this problem because the subsidies increase the gap between traditional FFS Medicare and private managed care. ▪ Because this drug benefit is provided through private companies and not through a standardized federal program, coverage will be erratic and it will be extremely complicated for seniors to understand. It will be very hard for seniors to figure out whether to enroll in the plan, and to determine which company's benefits will best suit them. Mistakes could be

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	$35 per month. Beginning in 2007, these amounts will increase to reflect the costs of the new Part D program for the previous year. By the year 2013, they are projected to rise to $58 per month in the case of the premium, and to $445 per year in the case of the deductible. ▪ The initial enrollment period will begin in November 2005, and will last six months. The Secretary of the Department of Health and Human Services is required to conduct activities that are designed to broadly disseminate information about the program for at least one month before the enrollment period begins. ▪ Seniors who sign up after the initial enrollment period will be assessed a penalty that will be built into their premiums forever. The penalty will total 1% for each month the senior opts out of coverage (reduced for seniors under 135% of poverty. The penalty can be waived if the senior can show that late enrollment is due to some change in his/her circumstances, such as job loss or loss of other coverage. ▪ The "standard" benefit pays 75% of prescription drug costs for the first $2,000 of medications above the $250 deductible. Then the benefit stops until the beneficiary has spent another $2,850 on covered medications. A total of $3,600 in out-of-pocket costs must be reached to be eligible for the catastrophic benefit: the $250 deductible, $500 in co-payments [25% of $2,000] and $2,850 on covered medications. ▪ Once the catastrophic benefit begins, seniors will pay 5% of covered prescription drug costs or co-payments of $2 for generics and $5 for brand names, whichever is higher. When combined with the deductible and the co-payments, seniors will need to have over $5,100 of covered prescription drug costs each year before they begin to benefit from the catastrophic coverage. ▪ Programs offering "actuarially equivalent" benefits could vary significantly from the "standard" model, including co-payments that are tiered, or higher than 25%, so long as they were "actuarially consistent" with an average expected 25% co-payment. ▪ Low-income seniors will be somewhat protected	very costly. Plans will have flexibility in setting premiums, the size of the coverage gap, and cost-sharing levels. Without a benefit that is standardized, it will be very hard for seniors to compare plans. ▪ It will be particularly difficult to evaluate the plans offering "actuarially equivalent" benefits because of the wide variation in benefits that could qualify. ▪ The value to seniors is based on estimates of what the costs will be, while few of the estimates are written into the law. For example, the highly publicized $35 premium is merely an estimate – the actual premium could be significantly higher by 2006, and will continue to rise with inflation. ▪ Plans will differ in which drugs they cover and in how much they charge for each drug on their "preferred" list (formulary). It is not clear if seniors will be able to easily find out which drugs are covered by the different plans or what the drugs will end up costing. Once they have signed up, seniors will be subject to unexpected costs if their medical condition changes and a drug not covered by their plan is prescribed by their doctor. Seniors will also be subject to unexpected costs if their plan drops drugs that were covered initially. Seniors will have a limited ability (likely once a year) to change plans once they have joined one. The Secretary will design these "open seasons", and will also establish a process for those whose circumstances change to apply for benefits. ▪ For those seniors who chose the full service option (e.g., HMO or PPO) rather than stand-alone drug coverage, the decision will be even more complicated. In those cases, not only will the drug benefits differ between plans, but so will costs for all the remaining health benefits provided. A change in a senior's health status could prove to be very costly. ▪ Those seniors who opt for the drug benefit will be prohibited from purchasing Medigap insurance that includes drug coverage. Although they are very expensive, many Medigap policies have much more generous prescription drug benefits than the private plans are expected to offer. While the Medicare plans

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	from the costs left uncovered under the bill. Those eligible for coverage under both Medicare and Medicaid with incomes below 100% of the federal poverty level ($9,310 for singles and $12,490 for couples in 2004) will be exempt from premiums and deductibles, and they will have no gap in coverage. They will pay a $1 co-payment for generic drugs and $3 co-payment for brand-name drugs. ▪ Low-income seniors with incomes under 135% of the poverty level (today about $12,569 for individuals and $16,862 for couples in 2004) will pay no premium and no deductibles, and will have no "gap" in coverage. They will pay $2 for each generic prescription and $5 for all other prescriptions. However, those with assets worth more than $6,000 ($9,000 for couples) in 2006 will not be eligible for this aid, regardless of their income levels. The bill does not specify which types of assets would "count" toward this asset total, but suggests only "liquid" assets are contemplated by Congress. The asset test is indexed for inflation. ▪ Seniors with incomes between 135% and 150% of the federal poverty level (today $12,569 - $13,965 for individuals and $16,862 - $18,735 for couples in 2004) will pay a sliding-scale premium and a $50 annual deductible. They will have 85% of costs covered up to the $3,600 out-of-pocket limit, after which they would pay $2 for each generic prescription and $5 for all others. Those with assets over $10,000 for individuals and $20,000 for couples (indexed for inflation) are ineligible for this assistance. ▪ Seniors eligible for both Medicare and Medicaid will get their drug benefit paid-for under Medicare instead of Medicaid, though the Medicaid program will continue to administer the benefit. States are prohibited from supplementing those benefits using joint federal-state Medicaid funds, though they are allowed to spend state-only money to expand benefits. The federal contribution toward the program will begin at 90%, phasing-down to 75% by 2015. ▪ Dual-eligible seniors living in nursing homes are exempt from the co-payment requirements. ▪ Once the benefit becomes available in 2006, seniors who opt for the benefit will no longer be	will likely be less expensive than any Medigap plan with drug coverage, the prohibition on purchasing Medigap prevents those seniors who have the money and chose to spend it for this extra coverage from doing so. ▪ There is virtually nothing in this bill that would help constrain the costs of prescription drugs. Even with the federal government picking up part of the tab, seniors could ultimately end up paying more than they do today for their medications. Drug reimportation won't happen under the system included in the bill, and the federal government is specifically banned from negotiating for lower prices with the pharmaceutical companies as do other agencies like the Veterans Administration. ▪ The benefits for low-income seniors will be administered through the state Medicaid programs. These programs vary from state to state, both in quality of administration as well as in substantive rules, and seniors will be treated differently depending on where they live. For example, although the amount for the asset test is set in the Medicare law, defining which assets will be counted will be determined by each state under its own rules. Some states currently include such items as burial plots and cars as "assets" for determining Medicaid eligibility, while others limit their definitions to bank accounts and investments. These inequalities of treatment will carry through to the drug benefit. ▪ For many seniors, the Medicaid program carries a stigma that is difficult to overcome. Having the low-income benefit administered by the state Medicaid programs will discourage many seniors from applying.

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	able to purchase Medigap insurance that includes drug coverage. ▪ Insurance plans that provide the benefit will receive subsidies to minimize the amount of risk they bear for the program (risk corridors). ▪ The federal government is specifically prohibited from using its bargaining power to negotiate lower prescription drug prices with the drug companies.	
EMPLOYER PROVIDED RETIREE BENEFITS	▪ Companies would receive subsidies for 28% of the cost of their retiree prescription drug costs between $250 and $5,000 in order to discourage them from discontinuing their plans. This subsidy is estimated to cost $70 billion over the next decade, and the cost comes out of the $409 billion estimated cost of the entire drug benefit. An additional $18 billion in tax benefits are provided as additional incentives. ▪ The subsidies are designed as cash payments from the government to employers, which include private companies, federal, state and local governments, and tax-exempt organizations such as charities and Indian tribes. ▪ The subsidy provided by the federal government does not count as income.	▪ No studies have been conducted to determine whether these subsidies will actually discourage companies from discontinuing their current retiree plans. To the extent that the subsidies fail, retirees will be left with a much worse benefit than they were receiving from their former employers since many of these plans require only a 20% co-payment and do not have gaps in coverage. ▪ There is nothing in the legislation that restrains the current trend of employers capping their liabilities with respect to their retiree plans, a trend that pushes more of the costs of health care on to their retirees. Because of this, companies can continue shifting costs on to their retirees while still collecting a significant subsidy from the federal government. ▪ The amounts contributed toward retirees' costs by their former employers does not count as an "out-of-pocket cost" when determining a senior's eligibility for catastrophic coverage. Because of this, few retirees with employer-provided coverage will ever reach the point of having 95% of their costs paid by the Medicare program, irrespective of how high their prescription drug costs are.
PRESCRIPTION DRUG COST CONTAINMENT	▪ The federal government is specifically prohibited from negotiating for lower prices with drug companies, a process that significantly reduces costs for veterans and others whose agencies are permitted to use their leverage to reduce costs for their beneficiaries. ▪ Reimportation of drugs is prohibited unless the Secretary of the Department of Health and Human Services certifies he/she can guarantee the safety of the imported drugs.	▪ Without effective cost containment, there is no reason to believe prescription drug costs won't continue to skyrocket. Much of the "benefit" for seniors in the bill will fade away in the face of increased costs. ▪ The combination of lack of cost containment plus increased subsidies to providers virtually guarantees that the federal portion of costs will rapidly reach the 45% threshold which has been set as the program's cost ceiling. Once this happens, an "emergency" will be artificially

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	▪ The bill makes it somewhat harder for brand-name drug companies to delay approval of generic copies. The legislation allows only a single 30-month delay of court proceedings when a generic firm challenges a brand-name drug's patent. The bill also allows multiple generic firms to qualify for the 180-day "market exclusivity" bonus, under certain conditions.	created, and seniors will be forced to accept large benefit cuts or cost increases. ▪ The Secretary of the Department of Health and Human Services has made it clear he does not intend to certify drugs reimported into this country as safe, despite the millions of Canadians and other non-Americans who use them every day. He claims it is because the origins of Internet sales can't be verified. But the drug companies have made it clear that the bigger problem is that other countries have placed limits on how much the cost of their prescription drugs can increase, so American drug consumers are footing the entire bill for the costs of developing and marketing the drugs. The bill simply allows American seniors to keep subsidizing drug consumers in other countries.
COST CONTAINMENT OF MEDICARE PROGRAM	▪ Beginning in 2005, the Medicare trustees will, for the first time, be required to calculate the income and outlays for all Medicare spending combined, and to project the growth of these combined Medicare costs to the general Treasury for seven consecutive years, as well as at 10-year, 50-year and 75-year intervals. ▪ The trustees are required to calculate whether, at any point during the 7 year period, general revenues are projected to reach 45% of total Medicare costs. ▪ The trustees also are required to project insolvency dates of the Medicare trust funds if general revenue funding is limited to 45% of total Medicare outlays. ▪ If the trustees project in two consecutive annual reports that general funding will exceed 45% of total Medicare outlays during the 7 year projection, this will be treated as a "funding warning" for Medicare. ▪ Designation of a "funding warning" triggers expedited procedures that are designed to make it easier to pass legislation that keeps general revenue contributions below the 45% "ceiling." These procedures include deadlines for the president to submit correcting legislation to Congress, as well as procedures designed to make it easier to bring that legislation to a vote in both the House and Senate.	▪ Those who oppose Medicare have been trying for years to combine Medicare's trust funds as a way of cutting Medicare funding. Without debate or review by any Congressional committee to see what the impact of this might be on Medicare, they will have effectively achieved their goal in this bill. ▪ Establishment of a 45% federal contribution threshold will inevitably accelerate the insolvency date for the program. ▪ The combination of lack of cost containment plus increased subsidies to providers virtually guarantees that the federal portion of costs will rapidly reach the 45% threshold, which has been set as the program's cost ceiling. Once this happens, an "emergency" will be artificially created, and seniors will be forced to accept large benefit cuts or cost increases. ▪ The 45% itself is an arbitrary number. There is no research indicating that is an appropriate level of funding by the government. ▪ The expedited procedures are set up in a way to make it much easier to enact legislation that cuts benefits or raises senior's taxes (in order to keep federal contributions below the arbitrary 45% cap) rather than simply raise or eliminate the cap. This tilts the balance heavily in favor of cutting Medicare.

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CHANGES TO MEDICARE'S PART B	▪ When a senior first becomes eligible for Medicare, a free voluntary physical will be available. ▪ New preventative benefits will be available, such as screening for diabetes and cardiovascular disease. ▪ A disease management program will be provided to manage and promote health for those with chronic illnesses. ▪ Beginning in 2005, the Part B deductible will increase by 10% to $110. Thereafter, the deductible will be indexed to reflect the growth in Part B expenditures. ▪ Under current law, premiums for Medicare's Part B (physician and outpatient) program are set to cover no more than 25 percent of program costs. Premiums are applied uniformly to all beneficiaries. Beginning in 2007, Part B premiums will begin to be means-tested. When fully phased in after seven years later, singles with incomes above $80,000 ($160,000 for couples) will pay premiums equal to 35% of program costs; seniors above $100,000 ($200,000 for couples) will pay 50%; seniors above $150,000 ($300,000 for couples) will pay 65%; and those above $200,000 ($400,000 for couples) will pay 80%.	▪ The increase in the Part B deductible is unprecedented, and it could end up imposing significant cost increases on seniors, whether they sign up for the new prescription drug benefit or not. Not only is the first increase at 10%, but further increases are pegged to the rising costs of health inflation, which was over 13% last year alone and estimated to rise to 17% next year. Because the bill itself contains significant subsidy increases for providers that will raise the costs of the Part B program, future growth rates could be even higher. ▪ Medicare was designed to be a universal program, not a welfare program for the poor. Means testing Part B erodes the equitable, fundamental nature of the program. ▪ Higher-income workers already pay more into the Medicare program than do those with lower incomes. Unlike Social Security, the Medicare program does not have a wage cap. In addition, higher-income workers generally pay higher income taxes, which help subsidize the Medicare program. They also are more likely to pay income tax on Social Security payments. ▪ Because the program will now be means tested, the Internal Revenue Service will share income tax information not only with the Social Security Administration, but also with the private companies providing the managed care options. This could have significant administrative costs, and it is a gross violation of seniors' privacy rights. This provision will be effective whether or not the senior participates in the new prescription drug coverage. ▪ Setting the means-testing thresholds at $80,000 and above saves the program very little money. Because of this, once means testing is in place, there will be a great temptation for future Congresses to significantly lower the point at which the income test begins. To save large amounts of money, the income limits would need to be reduced to the $30,000-$40,000 range.
PRIVATIZATION OF MEDICARE	▪ Beginning in 2006, HMOs and PPOs (Preferred Provider Organizations) would begin to bid for Medicare beneficiaries. A "benchmark" reimbursement will be established by blending	▪ While most of the public focus has been on the privatization "demonstration project" that begins in 2010, a form of competition between traditional fee-for-service Medicare and private

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	the costs of the various plans together with the cost of traditional fee-for-service Medicare. Seniors who chose a plan costing less than the specified "benchmark" would be allowed to pocket 75% of the difference between the premium and the "benchmark" rate. Those who chose a more expensive plan would be responsible for paying any additional costs.	managed care plans actually begins much earlier, in 2006. While the earlier privatization does not include the same head-to-head competition incorporated in the demonstration project, it sows the seeds for the demise of the traditional fee-for-service Medicare program, and it includes many of the same risks to seniors as does the demonstration project.
	▪ Beginning in 2010, up to six Metropolitan Statistical Areas (MSAs) will be selected by the government to participate in a six-year test of "comparative cost adjustment," (otherwise known as "premium support"). This experiment would require traditional fee-for-service (FFS) Medicare to compete directly with private plans such as HMOs and PPOs in each of the selected areas.	▪ It is estimated that five million to six million seniors could be involved in the demonstration project. Fully one-half of all states today have areas that qualify to participate in the experiment because they have regions in which 25% of beneficiaries are enrolled in private plans, and the number of qualifying states is expected to grow.
	▪ To be selected, an area would need to have at least 25% of beneficiaries already enrolled in private managed-care plans. Beneficiaries within a selected area will not be required to participate if their area has fewer than two private plans competing.	▪ A number of legislators, (who were well aware of the negative experiences in their states of previous privatization efforts), negotiated with the administration before they would vote for the legislation to have their constituents exempted from the experiment. Seniors living in these "favored" areas would therefore receive preferential treatment when compared with seniors who live in areas represented by legislators who opposed the bill and were therefore not able to negotiate similar exemptions with the Administration.
	▪ To set an area's premium, the government would take the annual per-beneficiary bid (how much it would cost the plan to provide health care to a beneficiary for a year) submitted by that region's traditional FFS Medicare, add to it the lowest per-beneficiary bids submitted by that region's private plans, and then figure an average. The government would then limit what it pays (annually per beneficiary) to that region's traditional FFS plan to that limit.	▪ For younger and healthier seniors, living in a selected area could mean lower costs, at least initially. But those in a selected area who choose to give up fee-for-service Medicare in favor of joining a private managed care plan must be prepared to give up their doctors and submit their treatment options to the cost-control managers at their new HMOs or PPOs – a choice millions of seniors have rejected in the past. And they must be prepared to live with the uncertainty of private companies possibly not being there for them for the long haul.
	▪ If the FFS costs per beneficiary exceed the average, beneficiaries will pay for the excess through higher Medicare premiums. These premium increases for seniors remaining in traditional Medicare will be limited to no more than 5% per year.	
	▪ Seniors below 150% of the federal poverty level with assets under $6,000 ($9,000 for couples) will be exempted from the experiment.	▪ The failed Medicare-Plus-Choice experiment is a good example of what happens when seniors become dependent on private companies, only to be abandoned when those companies decide their profit margins aren't big enough. Private companies participating in this privatization experiment will attract the most profitable seniors, who are the youngest and healthiest retirees.

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		▪ To entice the private sector into the experiment, the bill increases payments to private HMOs and PPOs by 20% to 30%. This is accomplished, in part, through a $12 billion discretionary fund that can be used to induce plans to participate. Private plans will become dependent on the excessive Medicare subsidies. This will inevitably encourage the private plans to hold Medicare – and the taxpayers who support it – hostage by threatening to leave an area unless the temporary subsidies are continued or increased. ▪ Promoters of the Medicare bill have implied that seniors who choose to stay in traditional fee-for-service will not be negatively impacted by this experiment. This could not be further from the truth, especially for seniors actually living in the demonstration areas. ▪ Currently, most (89%) Medicare beneficiaries are enrolled in traditional FFS Medicare. They include the nation's sickest, most expensive seniors, who often choose fee-for-service because they fear being denied benefits by private managed care plans, and because those with multiple chronic illnesses prefer fee-for-service's unlimited choice of providers. Medicare, as currently structured, successfully insures these sick, expensive seniors because it spreads the risk of doing this among millions and millions of beneficiaries nationwide. ▪ The demonstration project breaks up this large and successful nationwide risk pool. Under the demonstration project, each region would have its own risk pool, each with many fewer participants (on average, possibly less than one million per region). ▪ Yet just like seniors nationwide, the oldest and sickest seniors in demonstration areas would continue to opt to stay in FFS. The risk of insuring them would be spread among many fewer people. With no large risk pool to keep costs low and with sick, expensive seniors concentrated in FFS, seniors in a demonstration-project area would inevitably see their FFS premiums increase. ▪ Seniors in the demonstration areas who choose to stay in traditional FFS Medicare would pay

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		dramatically different premiums depending on the demonstration area in which they lived. Currently, all beneficiaries pay the same Medicare premium nationwide. Under the demonstration project, plans (including FFS) within a region would compete to provide Medicare beneficiaries' core benefits at the best price. Plans in that region spending less (per beneficiary annually) would charge lower premiums. Plans spending more (including FFS with its concentration of sick, expensive seniors) would charge higher premiums. Thus, the price of premiums within a demonstration area would vary. And the price between demonstration areas (of FFS premiums) also could vary dramatically, creating a system that would be perceived as unfair by those living in high-cost areas. ▪ According to Medicare actuaries, were Medicare to be fully privatized, premiums for traditional FFS Medicare would vary dramatically, even within a single state. For example, seniors in Queens, New York, would pay $2,000 a year in premiums, where those same seniors would only pay $975 if they were living in Erie, New York. Seniors lucky enough to live in Osceola, Florida, would pay only $1,000 per year compared with the $2,150 paid by their neighbors in Dade County, Florida. Examples like this would be duplicated all over the country. ▪ The privatization experiment will take us one big step further toward the demise of traditional FFS Medicare. Seniors in the demonstration areas who choose to stay in traditional FFS Medicare won't be able to avoid the additional costs simply by opting out of the new prescription drug coverage. The increases in their Part B premiums are not tied to acceptance of the new benefit. And part of their increases will go to pay for the subsidies being given to the private companies as inducements to participate in the experiment. The most vulnerable seniors – those in traditional FFS Medicare – will be called upon to help subsidize the very companies that drain healthier retirees from their risk pool and further increase their costs.
HEALTH SAVINGS	▪ Any taxpayer under age 65 covered by a high-deductible insurance policy ($1,000 for	▪ Health Savings Accounts (HSAs) are tax shelters for healthier, wealthier workers who are

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ACCOUNTS	individuals/$2,000 families) may open a tax sheltered Health Savings Account (HSA) to pay for expenses not covered by the policy. ▪ Up to 100% of the health plan deductible may be saved annually, up to a maximum of $2,600 for self-only policies and $5,150 for family policies (these amounts are indexed after 2004). ▪ Individuals age 55-65 can make additional "catch-up" contributions of up to $500 (rising to $1,000 by 2009). ▪ Contributions can be made by individuals, their employers, and family members – all on a tax-free basis. The contributions by individuals qualify for an above-the-line deduction (which means the deduction is available whether the taxpayer itemizes deductions or claims the standard deduction). Contributions by an employer are not included in the employee's taxable income and are deductible to the employer as a normal business expense. ▪ Earnings built up within the account are tax free, as are any distributions used to pay un-reimbursed qualified medical expenses for the account holder, spouse or dependents. Generally, HSAs may not be used to pay the premium on the high-deductible health insurance that must be purchased in connection with the HSA. However, tax-free distributions may be used to purchase qualified long-term care insurance, COBRA coverage, post-retirement medical coverage, and health insurance during a period of unemployment. HSAs may be included in a company's cafeteria plan. ▪ Expenditures prior to retirement age that are not used to pay for qualified medical expenses will be subject to both income tax and a 10% penalty tax. But once an account holder reaches age 65 (or becomes disabled), expenditures no longer need to be health related in order to be tax free. ▪ Amounts left in the account at death can be passed to a surviving spouse without losing any tax benefits. Once both partners have died, any assets in the accounts will be taxed at ordinary income tax rates over a five year period.	willing to be covered by high-deductible insurance policies. ▪ If they become popular, HSAs will further break up the insurance risk pool, draining away younger, healthier workers and leaving those with generally higher health expenses covered by traditional policies. To the extent this happens, costs for these policies will rise. ▪ Companies are already switching to "consumer-driven health care" policies in which their contributions toward their workers' health insurance are capped and the employees bear most of the risk of the skyrocketing costs of health care. HSAs could provide additional incentives for employers to switch from offering traditional insurance policies to offering the high-deductible policies necessary to qualify for the HSA. Limited employer contributions combined with high-deductible policies could become the "standard" available to all workers, forcing even those who prefer the traditional policy to accept the high-deductible policy or pay more to keep their current insurance. ▪ HSAs were paid for in the bill by using the tax revenues employers are expected to save by eliminating their retiree health coverage (as a result of the passage of this bill). In effect, the bill's authors themselves acknowledge the bill will further encourage companies to drop their retiree health plans. They then use the money this raises to create even more incentives that will break up the risk pool and raise costs for those who need comprehensive insurance coverage the most. ▪ HSAs are the only tax shelter available to the wealthy that gives a tax break for both contributions to, and withdrawals from, the account. HSAs themselves are expected to drain almost a half-billion dollars every year from the Treasury by the end of the decade, with increased costs expected in subsequent years. ▪ If the HSA model (of giving both tax-free contributions and earnings without income limits) catches on for other, non-health related priorities, Congress could be opening the door to losing unknown billions of dollars of revenue. This will cause deficits to explode even more than we're now expecting, with most of the

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		revenue loss coming at the peak of baby boomer retirements – just as the Social Security and Medicare trust funds will be under the most pressure.
PROVIDERS	**HOSPITALS:** ▪ For fiscal year 2004, the rate of change in payments to hospitals would match the rate of change in the price for a "market basket" of certain goods used by hospitals. ▪ For fiscal years 2005-2007, hospitals will have to furnish information on quality to the Centers for Medicare and Medicaid Services or face a reduction in payments. ▪ The bill imposes an 18-month moratorium of the self-referral whole hospital exemption for new specialty hospitals, not including existing hospitals or those under construction. ▪ Other technical changes are made to provide increased payments to selected facilities such as high-quality hospitals, those with large numbers of employees that commute, skilled-nursing facilities with large numbers of AIDS patients, hospices, hospitals in Puerto Rico, etc. **PHYSICIANS:** ▪ The currently scheduled cut of 4.5% in both 2004 and 2005 will be replaced with a payment increase of at least 1.5% in both these years. ▪ 5% bonus payments are provided for physicians practicing in areas where there is a scarcity of doctors from 2005 - 2007. ▪ Screening tests are authorized for early detection of cardiovascular disease and diabetes. Mammograms provided in hospital outpatient departments are reimbursed under higher rates. ▪ The bill includes increased payments for a variety of procedures and specialties, such as pediatric dialysis, podiatrists, dentists, optometrists, custom shoes for diabetics, etc. ▪ The bill provides some reductions in payments for drugs through changes in the average wholesale price schedule beginning in January	▪ Providers have complained that reimbursements for their services have been insufficient, particularly in recent years. Some have withdrawn from the Medicare program or limited the number of new Medicare patients they are willing to serve. At the same time, however, research has shown other providers are overpaid for the services they provide. The National Committee has not attempted to evaluate these claims. In general, we support ensuring that providers receive reasonable reimbursement, so that seniors have available the broadest range of providers and treatments. ▪ However, to generate support for the legislation, the bill increased payments to most providers, at least in the short run. Some of these increases were incorporated in the $409 billion cost of the legislation, and this reduced the overall amount available for the prescription drug benefit itself. The shortage of funds made it necessary to create the benefit's gap in coverage, and impacted the size of the required premiums and co-payments. ▪ Increasing payments to providers also increases Medicare's overall costs, driving the program more quickly toward the bill's 45% federal contribution threshold (which is designed to facilitate reductions in the program). Increasing provider payments also accelerate the insolvency date of the trust funds.

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	2004. **LABORATORY PAYMENTS:** ▪ Payments are frozen for five years **DURABLE EQUIPMENT:** ▪ Reimbursement rates on crutches, walkers and other durable equipment will be frozen from fiscal year 2004 to 2006, with reductions applied to some items and services. ▪ Competitive bidding in the 10 largest metropolitan areas will begin in 2007, with a goal of 80 such areas by 2009. **AMBULATORY SURGICAL CENTERS:** ▪ The bill includes a 1% reduction in payments beginning in April 2004, with a freeze in payments from 2005 - 2009. **HOME HEALTH CARE:** ▪ No co-payment required, same as current law. ▪ Rural home health care providers are given a 5% bonus for one year; all other providers take a small reduction from 2004 - 2006. **RURAL PACKAGE:** ▪ The bill provides higher payment levels to rural and small urban hospitals that have a disproportionate share of low-income patients, and to hospitals in outlying areas that have a low volume of patients.	

DISCOUNT CARD BENEFIT (June 2004-December 2005)		
STANDARD BENEFIT *Singles over $12,569;* *Couples over $16,862 (in 2004)*	**100% OF POVERTY** *Singles under $9,310;* *Couples under $12,490 (in 2004)*	**135% OF POVERTY** *Singles $9,310 - $12,569;* *Couples $12,490 - $16,862* *(in 2004)*
• Estimated 10% - 15% savings off total drug spending	• $600 credited on card • 5% co-pay on covered drugs • State may cover beneficiary costs with state funds only	• $600 credited on card • 10% co-pay on covered drugs • State may cover beneficiary costs with state funds only

PRESCRIPTION DRUG BENEFIT (Beginning January, 2006)			
STANDARD BENEFIT *Singles over $13,965;* *Couples over $18,735* *(in 2004)*	**100% OF POVERTY** *Singles under $9,310;* *Couples under $12,490* *(in 2004)*	**135% OF POVERTY** *Singles $9,310 - $12,569;* *Couples $12,490 - $16,862* *(in 2004)*	**135% to 150% OF POVERTY** *Singles $12,570 - $13,965; Couples $16,862 - $18,735* *(in 2004)*
• $35 estimated monthly premium [indexed] • $250 deductible [indexed] • 25% co-pay on covered drugs from $251-$2,250 [indexed] • 100% co-pay on covered drugs from $2,251-$5,100 [indexed] (equivalent to $3,600 out-of-pocket spending) • 5% co-pay on covered drugs over $5,100 total covered costs [indexed]	• $0 monthly premium • $0 deductible • no gap in coverage • $1 co-pay for generics; $3 co-pay for name-brands • must be Medicaid eligible • nursing home dual eligibles exempt from co-pays	• $0 monthly premium • $0 deductible • no gap in coverage • $2 co-pay for generics; $5 co-pay for name-brands • subject to asset test ($6,000 singles/$9,000 couples) [indexed]	• sliding scale premium • $50 deductible [indexed] • 15% co-pay on covered drugs up to $5,100 [indexed] • $2 co-pay for generics over $5,100; $5 co-pay for name-brands • subject to asset test ($10,000 singles/$20,000 couples) [indexed]

Note: All Income Thresholds are 2004 data, not projections to the effective dates.

Department of Policy Research, April 2004