

FY1

OTHER FACTS: 65% All Bene = Cover. Drugs
- 55% ALL HMO ENROLLEES
86% Bene use prior. Drugs
Avg = \$600 exp/year
\$691 w/coverage
432 w/o coverage
458 = HMO

Drug Coverage in Medicare Risk Plans

This paper provides a descriptive analysis of drug coverage available to Medicare enrollees of risk HMOs and competitive medical plans during the 1998 contract year. The information is based primarily on the description of benefits included in the Medicare Compare data available through the "medicare.gov" Internet site. Enrollment information is based on the data included in the June, 1998, monthly report. Because not all plans appear in each data base, the analysis does not include information on 7 of the 322 risk plans operating as of the beginning of the 1998 contract year. However, the included plans represent 98% of enrollment as of June, 1998 (5.6 million out of 5.7 total). Most of the analysis of specific features of Medicare drug coverage in risk plans applies to plans offering drug coverage in all basic benefit packages—that is, the plans included in the analysis offer drugs to all enrollees, in all counties, at no extra cost. Except as otherwise noted, the analysis excludes drug coverage offered only to some enrollees as "flexible benefits" available in only some counties, or drug coverage offered only as supplemental benefits for which there is an additional premium charged. Other limitations of this analysis are described in detail in the appendix.

Coverage Information: General (All Plans)—Figure 1

Plans With Some Level of Drug Coverage

- There are 4.1 million beneficiaries enrolled in the 214 plans that include some level of drug coverage in the basic benefit package. That is, 72% of all Medicare risk plan enrollees are enrolled in plans that provide drug coverage to all enrollees as part of the basic benefit package.

Plans With No Drug Coverage or Drug Coverage Available only to Some Enrollees

- No Drug Coverage or Coverage for Only Some Enrollees.** A minority of plans, representing 28% of total risk enrollment, do not include drugs in all basic benefit packages.
- Coverage for Some Enrollees.** However, 19% of all risk enrollees (one million beneficiaries) are enrolled in 64 plans that (a) offer drugs to some enrollees through basic benefit packages available only in some portions of their service area, or (b) offer drug coverage as a supplemental benefit (i.e., the enrollee must purchase (or have his or her employer purchase or contribute towards) a separate premium for drug coverage).
- No Drug Coverage.** Twelve percent of plans (37 plans) appear not to offer any type of drug coverage to Medicare risk enrollees. Only nine percent of risk enrollees are enrolled in such plans (one-half million beneficiaries).

Payment Levels and Drug Coverage (Figure 2)

- On average, the higher the level of Medicare capitation payments, the more generous a plan's drug coverage is likely to be.

Unlimited Drug Coverage—Figure 3

Drug Coverage with No Annual Dollar Limit

- ▶ **1.6 million beneficiaries enrolled in 35 plans (40% of all enrollees) have drug coverage for which there are no annual dollar limits (though cost-sharing and restrictions may apply, such as providing for unlimited coverage of generics but imposing dollar limits on brand-name drugs).**
- ▶ Of the 35 plans, six plans, with 147,000 enrollees, have unlimited drug coverage (though some restrictions may apply) for which there are no copayments on any type of drug (i.e., four of these plans apply limits based on generic, brand, formulary, or mail order, but they do not require any copayments).
 - ▶ Among the six plans with no copayments, only one plan, a Florida plan with 24,000 enrollees, states that it offers unlimited drug coverage without restrictions. There are no copayments required in this plan, making it the only plan that appears to have completely unrestricted, free drug coverage.
 - ▶ Another Florida plan, with 16,000 enrollees, has no dollar limit on generic drugs and no dollar limit on brand-name drugs if generics are unavailable. This plan requires no copayments on drugs.
- ▶ The third largest plan in the country, with 211,000 enrollees, offers unlimited drug coverage for drugs purchased through its in-house pharmacy.
- ▶ The largest plan in the country, with over 400,000 enrollees, imposes no limits on generic drugs in any county of its service area, but, under HCFA's flexible benefits policy allowing county variation, the plan imposes a dollar limit on brand name drugs in two Southern California counties. For this plan, a total of 405,000 enrollees have unlimited generic and brand coverage, while the 36,000 enrollees in the two flexible benefit counties have brand limits.

Dollar Limits (*In Plans Offering Drugs in All Basic Packages*)—Figure 3

- ▶ Where an annual dollar limit is applied, the most common limit is \$1000 per year. Nearly one quarter of enrollees are members of the 48 plans with the \$1000 limit.

- ▶ About one-third of plans (with 24% of total enrollment) offering drug coverage in all basic packages have an annual dollar limit of less than \$1000.
- ▶ Dollar limits can vary by type of drug. There are 44 plans that have differential limits for brand versus generic drugs, and 20 plans that have different limits for formulary versus non-formulary drugs.

Cost Sharing (*In Plans Offering Drugs in All Basic Packages*)

Copayments—Figures 4, 5, 6

- ▶ *The great majority of plans require copayments for drug coverage.*

Figures 5 and 6 illustrate the levels of copayments among plans. In this analysis, a distinction is made between minimum and maximum copayments to recognize that the majority of plans have differing levels of copayments based on characteristics of the drugs being prescribed or how they are obtained (as in the example cited in the preceding paragraph, as well as differences based on mail order purchase, use of contracted pharmacies, etc.).

- ▶ A total of 56 plans, with 827,000 enrollees make a distinction in copayment levels based on whether a drug is a formulary or non-formulary drug. There are 122 plans, with 2.2 million enrollees, that require a higher copayment for non-generic, versus generic drugs.
- ▶ However, 56 plans, with 1.28 million enrollees, have a uniform level of copayment for covered drugs.

The highest level of copayment for a plan offering some form of no-dollar-limit drug coverage is the maximum \$50 per scrip charged by an Oregon plan (with 34,000 enrollees), which requires a 70% coinsurance on drugs up to the \$50 limit (with no annual maximum coverage for drugs obtained through the in-house pharmacy or elsewhere if included in the plan formulary). The 70%/\$50 maximum applies to all drugs for this plan.

The next highest level of copayments is among five plans (with a total of 75,000 enrollees) which require a \$30 copayment for brand-name, or brand non-formulary drugs.

Three plans, all in California, with 124,000 enrollees, require a \$25 copayment on brand or non-formulary drugs while charging \$5, \$7, and \$8 as the copayment for drugs not subject to the higher copayment.

Some plans have several levels of copayment. One plan, for example, requires a \$5 copayment for a 30-day supply of covered generic prescription drugs, a \$15 copay for brand-name drugs appearing on the plan formulary, and a \$30 copay for brand-name non-formulary drugs.

Deductibles

- ▶ Other than in the State of Wisconsin, where a State mandate determines the type of drug coverage (a \$6250 deductible and 20% coinsurance thereafter), only one plan requires a deductible to be met before coverage is provided. (In the State of Wisconsin, no plan offers drug coverage at a higher level than required by the State mandate, even though this is permissible.)

Coinsurance

- ▶ It is not common for Medicare risk plans to use coinsurance as a type of cost-sharing for drug coverage.

Only 16 plans (187,000 enrollees) apply coinsurance to drug coverage. (including the four Wisconsin plans). Only three plans have coinsurance applicable to any type of drug (at 50%), but these plans have very limited coverage in general: the highest level of coverage is a \$400 annual limit on the amount to be reimbursed by the plan. Two other plans have across-the-board coinsurance but make a distinction between Medicare-covered (20%) and non-Medicare-covered (50%) drugs. These plans also have very limited coverage (\$500 and \$200 per year, with no limit permitted on Medicare-covered drugs).

Other plans make a distinction between generic (no coinsurance) and non-generic drugs. One plan specifies that there is a distinction based on a formulary applicable to all drugs. Two plans only cover drugs obtained through in-house pharmacies.

The highest coinsurance charged is 80%, which one plan applies, but only to brand-name drugs (with no coinsurance on generic drugs obtained through the plan's pharmacies). Another plan (of the same chain of HMOs) charges 70% coinsurance on all drugs, up to a maximum of \$50 per prescription.

As noted above, two plans charge a 20% coinsurance for Medicare-covered drugs, with a higher coinsurance (50%) applicable to non-Medicare-covered drugs. One plan charges 20% coinsurance only on Medicare-covered drugs (see comment below on immunosuppressives) with no coinsurance applicable to non-Medicare-covered drugs.

Five plans require coinsurance for immunosuppressive drugs while not requiring it for other drugs, and one plan specifies different levels of coinsurance for immunosuppressives based on inclusion in the plan formulary. One plan requires coinsurance only for a specific drug (Lupron and Lupron-Depot) and no other drugs.

Use of Formularies

The Medicare Compare data may not indicate all plans that use formularies. As noted above, 56 plans specify copayment differences based on formulary status of a drug, and twenty plans have differences in dollar limits (yearly caps) based on formulary status. Seven plans have formulary/non-formulary differences for both copayments and caps. Hence, at least 56 plans use formularies in determining the extent of drug coverage.

Over-the-Counter Drugs

- ▶ One plan offers coverage of over-the-counter drugs, limited to \$15 per month. Another plan includes vitamins and over-the-counter drugs prescribed by a physician as covered but counting towards the overall \$600 yearly limit for drug coverage.

Appendix: Methodology and Limitations of Study

We have attempted to provide the most conservative estimate of the maximum number of Medicare beneficiaries who have drug coverage. Therefore, we generally describe only the drug benefits of plans that include drug coverage for all enrollees in all basic packages, and we describe the features of the least generous level of drug coverage when multiple options are offered by a plan. The variation in packages is generally due to the use "flexible benefits," whereby plans can vary coverage in different counties of the same service area.

What is not known from this analysis, in addition to the extent to which beneficiaries obtain optional (supplemental) drug coverage through their risk plan, is the extent to which Medicare-eligible retirees enrolled in employer-sponsored Medicare risk plans are obtaining drug coverage that is not available to other Medicare enrollees in the plan. A recent analysis based on data from the Medicare Current Beneficiary Survey indicates that 95% of enrollees of risk plans have drug coverage, while this analysis indicates that nine percent of the total number of beneficiaries enrolled in risk plans are enrolled in a plan that offers no drug coverage of any kind. The difference in the two analyses is partly attributable to the number of beneficiaries who have drug coverage as employer-group-connected enrollees of Medicare risk plans. HCFA has no information on the extent of drug coverage offered to employer group retirees through Medicare risk HMOs.

The information included in the Medicare Compare data are assumed to be accurate. However, for 1998, HCFA had not standardized the language to be used in describing drug coverage. In some cases, plan representatives were called to obtain clarification of coverage. When the Medicare Compare information includes language such as "same as Medicare fee-for-service & prescription drug plan" or "same as Medicare coverage limitations plus \$1000 annual limit on prescription drugs," or "same as Medicare fee for service" and then specifies an annual limit, this is assumed to mean that the plan covers non-Medicare covered drugs and that the annual limit applies to such coverage (since plans would be prohibited from applying any caps on Medicare-covered drugs). This assumption is based on a conversation with a plan representative about how the plans were expected to complete information for Medicare Compare.

Although several plans were called for clarification of the description of coverage, there remain gaps in information regarding some of the plans (limited to a small number of enrollees). Not all subcategories include all plans. That is, if information is missing on certain aspects of plan coverage, the plan may be excluded from some subcategories but not from others. Wisconsin plans are only included in some of the analyses because of the anomalous nature of the drug coverage as compared to coverage in other plans. The State (until Medicare+Choice pre-emption takes effect) requires plans to offer drug coverage, consisting of coverage of 80% of actual charges after having met a deductible of \$6250 per year.

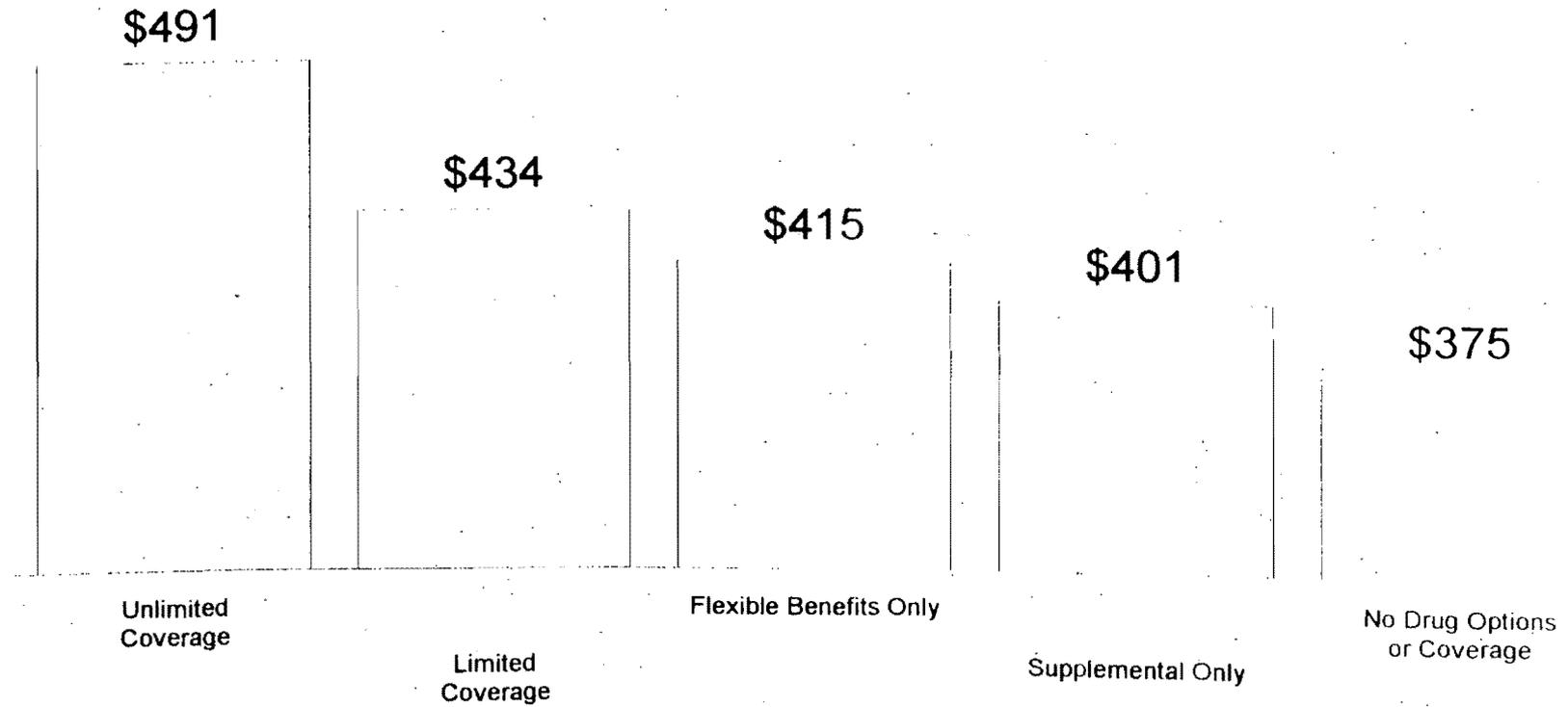
The following information should also be noted:

- ▶ Insignificant discounts (e.g., \$2 off generic; \$1 off brand), or coverage characterized as “discounts available,” are classified as “no coverage.”
- ▶ If quarterly or monthly limits apply, amounts are annualized to determine yearly limits (thus overstating coverage). At the same time, “carryovers” are ignored. That is, if the plan says that when an annual/quarterly/monthly limit has not been exhausted, it can be carried over to the following period, the analysis ignores this effect.
- ▶ When the Medicare Compare information refers to “preferred drugs,” the plan is categorized as applying a formulary.
- ▶ The term *plan* in this context refers to a contract area for a given organization, which encompasses a specific service area. One organization may have multiple Medicare plans in different areas of the country, or even in contiguous areas. Enrollment figures are for each separate plan of a given organization.

Distribution of Types of Drug Coverage by Number of Enrollees and Number of Plans

Type of Drug Coverage	Number of Enrollees	Percent of All Enrollees	Number of Plans	Percent of All Plans
Drugs in All Basic Plans	4,095,083	72.4%	214	67.9%
No Drugs or Flex/Option Only (Broken Out Below)	1,563,473	27.6%	101	32.1%
<i>Drugs as Flexible Benefit or "Compare" Listed Option</i>	730,716	12.9%	50	15.9%
<i>Drugs as Supplemental Only</i>	327,951	5.8%	14	4.4%
<i>No Drug Coverage at All Offered by Plan</i>	504,806	8.9%	37	11.7%

Average Monthly Medicare Capitation Payment Per Enrollee, by Extent of Drug Coverage Available in Plans, June, 1998



Distribution of Annual Limits Among Plans with Drug Coverage in All Basic Plans

Level of Annual Limit	Number of Plans	Percent of Plans	Number of Enrollees	Percent of Enrollees
TOTAL in Group*	209		4,062,530	
No Dollar Limit	35	17%	1,630,640	40%
Some Dollar Limit	174	83%	2,431,890	60%
> \$2000 to \$3600 (top limit)	6	3%	140,118	3%
> \$1000 to \$2000	50	24%	644,789	16%
= \$1000	48	23%	689,500	17%
> \$500 to < \$1000	31	15%	473,093	12%
\$500 or less	39	19%	484,390	12%

*Percentages are of total in group, which is all plans with coverage in all basic options except the four WI plans and one plan with dollar limit unspecified (5 plans, enrollment of 32,553).

Basis for Differences in Copayment Levels

	Number of Plans	Percent of All Plans With Coverage in All Basic Plans	Enrollees	Percent of All Enrollees in Plans with Coverage
Subset of Plans Using Copayments	177	83%	3,568,469	87%
No Differential Copayments	44	24.5%	1,112,558	30.3%
Differential Copayment Levels Based on:*	133	Percent of Subset	2,555,599	Percent of Subset
<i>Formulary/Non-Formulary</i>	24	18.0%	458,788	12.7%
<i>Generic/Non-Generic</i>	90	67.7%	1,956,478	53.9%
<i>Generic and Formulary</i>	16	12.0%	140,639	3.9%

Maximum Copayment Levels in Plans with Differential Copaymen

Maximum Copayment	Number of Plans	Percent of Plans	Enrollees	Percent of Enrolles
= \$30	5	3.8%	75,105	2.9%
= \$24 or \$25	29	21.8%	840,995	32.9%
= \$20	18	13.5%	227,426	8.9%
> \$10 and < \$20	50	37.6%	975,467	38.2%
= \$10	28	21.1%	421,167	16.5%
< \$10	3	2.3%	15,439	0.6%
Total	133		2,555,599	100

Excludes plans with coinsurance, deductibles, unstated limits.

Minimum Copayment Levels for Plans with Differential Copayments

Copayment Level	Number of Plans	Percent of Plans	Enrollees	Percent of Enrollees
Less than \$5	6	5%	64,805	2.8%
Five Dollars	61	46%	1,515,260	65.4%
Over \$5 and Less than \$10	40	30%	737,122	31.8%
Ten Dollars	26	20%	238,412	10.3%
TOTALS	133		2,317,187	

Excludes plans with unstated copayments, deductibles, coinsurance. Aside from the excluded plans, no plans have minimum copayment levels in excess of \$10.

Parameters of a Premium Support Program for Medicare: Options and Tradeoffs

An earlier paper presented to Commission members discussed the key questions involved if Medicare were to shift to a premium support system. The paper raised questions in a number of key issue areas, including benefit design and contribution design.

There was a desire on the part of many Commissioners to take the discussion to the next level: to describe and analyze how specific design parameters might work, e.g., how the government contributions might be set, how plans would bid, etc. This paper will attempt to provide specific design parameters, illustrating different policy alternatives relevant to key provisions. The advantages and disadvantages of different alternatives will be discussed at key decision points.

In building a plan and weighing the advantages and disadvantages of different provisions, there are some goals to keep in mind. Early in the Commission's deliberations, Dr. Reischauer presented four key concerns for the future of the Medicare program:

- I) Insolvency,
- II) Inadequacy,
- III) Inefficiency, and
- IV) Inequity.

As the different options are discussed, these four concerns will be considered.

I) Administration

One of the more vital aspects of a premium support system would be setting up an efficient administrative structure that would facilitate both the management of the overall program and the day-to-day operation of the traditional plan. One way to accomplish this goal could be to have two separate organizations--a Medicare board, which would oversee all the plans in the premium support system, and HCFA, which would administer the traditional fee-for-service (FFS) plan. This would avoid a conflict of interest between management of the overall system and

complicated and may reduce prudent consumer purchasing. This is essentially an efficiency argument. Second, benefit variation can readily lead to risk segmentation (adverse selection) problems. People with higher expenditures (e.g., some of the chronically ill) will congregate in those plans with richer benefits, resulting in premium differences driven by population characteristics, rather than plan efficiency or even the actuarial value of any additional benefits. The second argument is concerned with the inequity that might result from sicker people paying higher premiums and the inefficiency created when plans pursue healthier people rather than the provision of quality care in a cost-efficient manner. This second concern would be at least partially addressed through the use of a risk-adjusted government contribution.

Arguments for benefit variation mostly focus on enhanced beneficiary choice, i.e., that "one-size-fits-all" benefit design ignores variation in needed benefits that exists in the population. There are benefits that may be attractive to beneficiaries that do not necessarily fuel adverse selection. Beneficiaries could make reasonable choices between benefits, such as dental, vision and hearing aids, to better match their health needs to their Medicare coverage. This argument addresses the inadequacy concern that Medicare does not cover the benefits beneficiaries want and need.

One possible alternative would be to require plans to cover a core set of benefits or core categories of benefits, which are at least actuarially equal to the current Medicare FFS package, but allow plans reasonable flexibility in designing specific provisions similar to FEHBP.

B) Possible benefit provisions in FFS package -

The desire to improve the adequacy of the Medicare benefit package is balanced by concerns over the solvency of the program. Efficiency plays a role as well. A more rational cost-sharing structure could reduce the need for inefficient supplementary coverage.

Medicare's current cost-sharing structure is an area of clear concern to both beneficiaries and analysts. For example, unlike typical employment-based coverage, the Medicare fee-for-service (FFS) plan has no maximum out-of-pocket protections for beneficiaries. It also lacks 365 days of hospital coverage or

coverage for outpatient prescription drugs.

“Sample FFS Benefit...” in your briefing material displays some of the tradeoffs involved. It provides cost estimates of the effects of changing the benefits Medicare offers.

“Sample FFS Benefit...” shows the effects of providing maximum out-of-pocket protection to beneficiaries and what effect that has on costs and solvency. It also introduces some possible benefit tradeoffs, i.e., cost-sharing or other changes in current coverage that might be used to finance maximum out-of-pocket limits without adding to the risk of insolvency.

Raising hospitalization coverage to 365 days is also examined. The current FFS benefit can leave beneficiaries without health insurance after 150 days and has been criticized for fueling beneficiaries' fears of massive financial liabilities.

Options for offering outpatient prescription drug coverage are also examined. Prescription drug coverage is often costly and drug costs are growing at a faster rate than almost any other category of benefits.

These different benefit combinations tend to fall into two important categories: benefit changes that can be made without adding to the overall costs of the program and changes that will add to overall costs. An example of the first type of change would be combining the Part A and B deductibles. An example of the second type of change would be adding outpatient prescription drugs to the current benefit package.

C) Coordinating public and private benefits -

An important area of benefit design is how Medicare coordinates its coverage with other insurers, e.g., Medigap, employers, and Medicaid. There is a clear desire on the part of beneficiaries for supplemental coverage. One of the advantages of a premium support system is that it more readily facilitates an integration of benefits and financing from multiple sources. The purchase of supplemental coverage is much less common among the younger than 65 population. That population tends to have employment-based coverage, which typically has very different cost-sharing and benefits than Medicare FFS coverage.

The presence of first dollar coverage would not be as large of a concern if it did not increase Medicare's costs. Research conducted by the Physician Payment Review Commission (now the Medicare Payment Review Commission) estimated the effect on Medicare's costs when supplemental insurers, rather than beneficiaries themselves, pay Medicare's deductibles and other cost-sharing. Figure 1 displays the effects of supplemental insurance on Medicare's costs. The major area of concern is not employers, who typically fill-in their retirees' Medicare cost-sharing to levels comparable to their current workers, e.g., \$250 deductibles. The major area of concern is Medigap insurers who fill-in 100 percent of the cost-sharing, so beneficiaries face no costs no matter how much they consume.

Figure 1. Comparison of Projected Per Capita Spending for Average Beneficiaries, by Type of Supplemental Insurance and Year



Note: These spending levels represent the expected differences in outlays after other factors have been taken into account.
Source: Physician Payment Review Commission analysis of data from the 1993 and 1995 Medicare Current Beneficiary Survey. The sample size for 1993 was 11,285 and the sample size for 1995 was 13,251.

One of the advantages of a premium support system is its ability to easily integrate primary and supplemental insurance coverage through its contribution.

While beneficiaries might still purchase supplemental coverage, additional contributions can easily be made by employers, beneficiaries, or other sources without doing harm to the actuarial underpinnings of the primary plan by filling in cost-sharing provisions.

“Sample FFS Benefit...” also provides illustrations of how Medigap coverage might be better integrated with Medicare. Different options are presented that move away from the inefficient and costly aspects of first dollar coverage, while recognizing the beneficiaries’ desire for adequate coverage and protection from financial liability.

III) Designing the Contribution -

There are three key considerations in designing the government contribution: A) How the contribution should be set in the first year of the new system, B) How the contribution should be set in future years, and C) How the contribution should be allowed to vary - by beneficiary characteristics such as geographic region, out-of-pocket expenses, income and assets, or some other criteria, such as risk?

A) Setting the contribution in the first year -

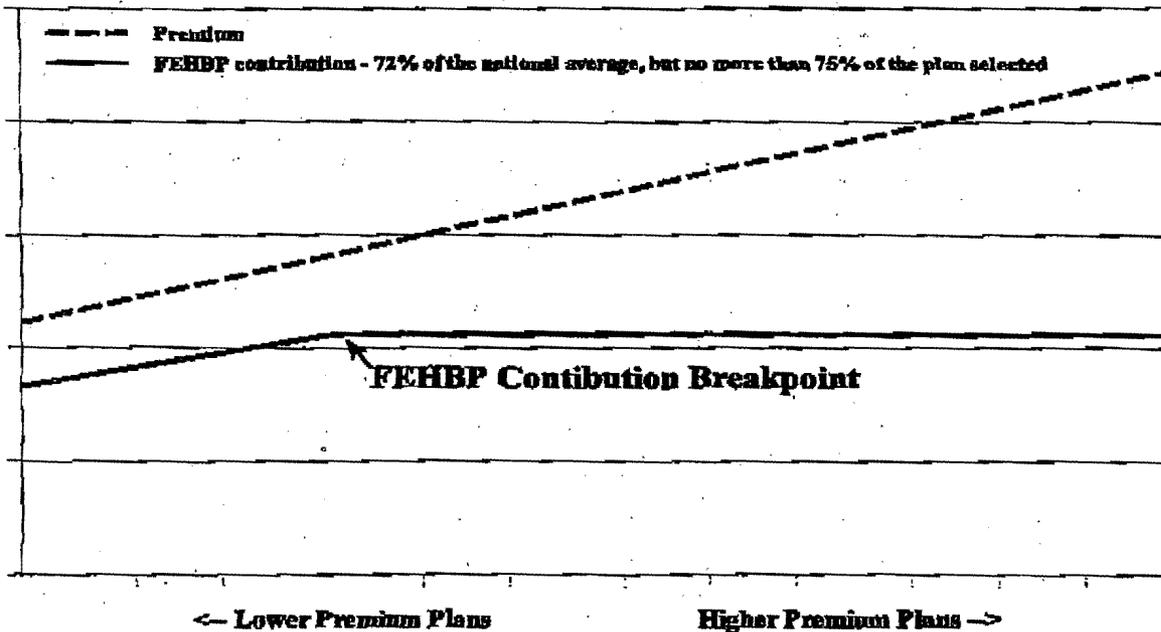
The level of premium support can be set at any point policymakers decide. In employment-based health insurance, employers typically contribute a percentage of the premiums, currently about 80 percent. In FEHBP, the contribution is about 72 percent of the average premium. Medicare does not have an actual premium for the fee-for-service (FFS) program. The closest measure to a Medicare FFS premium is benefit cost per beneficiary, excluding beneficiary cost-sharing. The beneficiaries pay 10% of these costs through their Part B premium.¹ In employment-based health insurance the beneficiaries are expected to share more of the expenses, but they also receive more comprehensive benefits. In Medicare, the

¹ This 90% - 10% split between the government and beneficiaries apply to Medicare-covered benefits only. Examining total spending for Medicare beneficiaries, including non-covered benefits and other out-of-pocket expenses, indicates that beneficiaries and their previous employers cover about 34% of total spending, with Medicare covering about 48%. Other government sources, like Medicaid and the VA, cover the remaining 18%. Source 1995 Current Beneficiaries Survey (CBS), Office of the Actuary, HCFA.

beneficiaries pay a lower share of benefit costs and receive less comprehensive benefits.

In designing the contribution, it is important to ensure that the incentives created for both the plans and the beneficiaries result in competitive behavior among plans and prudent consumer behavior by beneficiaries. The FEHBP contribution has been credited with giving both plans and subscribers strong incentives to keep premiums below the point where the government's contribution stops increasing, that is where the contribution is a fixed amount no matter how high the premium. FEHBP is criticized for not providing enough incentives to both plans and subscribers to select premiums below this "bend point" where the government contribution stops increasing (see figure 2).

Figure 2 - Hypothetical Premium Support Using the FEHBP Formula



To address these concerns, the contribution to the Medicare premium support system could be designed to provide incentives for plans and beneficiaries

to offer and choose plans below a single, strict FEHBP-style bend point. The following algorithm attempts to provide those incentives:

1) For plans with premiums below 90 percent of the national weighted-average premium, the contribution would be X percent of the premium.²

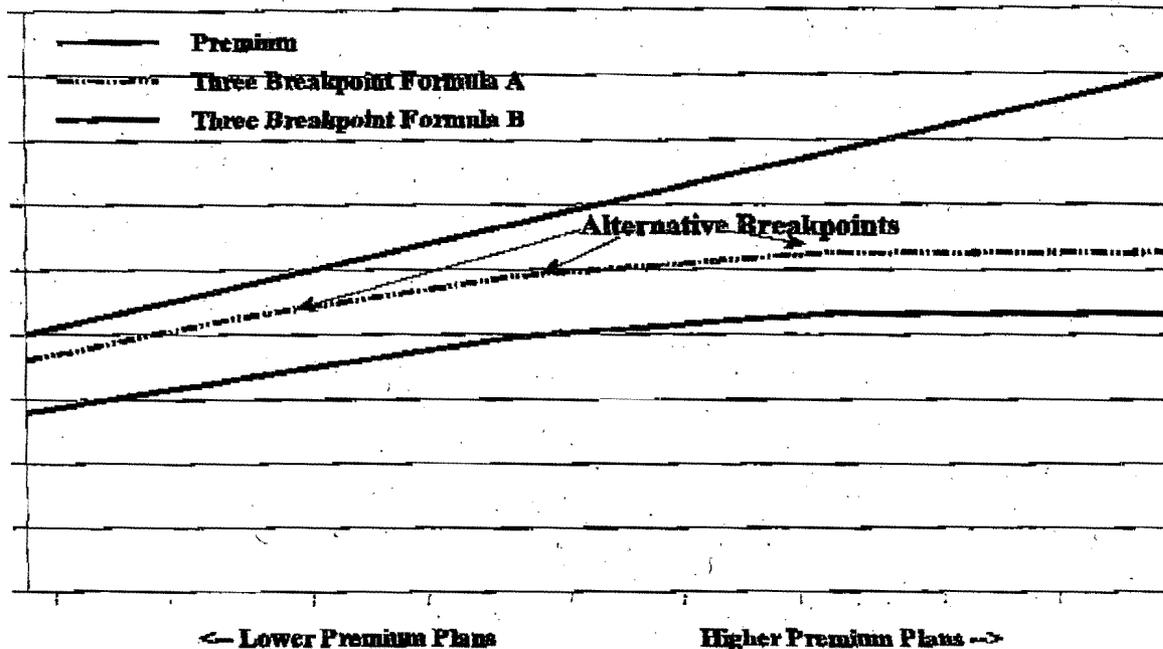
2) For plans between 91 and 110 percent of the national weighted-average premium, the contribution would increase \$2 for every \$1 the beneficiary paid in additional premiums.

3) For plans between 111 and 130 percent of the national weighted-average premium, the contribution would increase \$1 for every \$2 the beneficiary paid in additional premiums.

4) For plans above 130 percent of the national weighted-average premium, the contribution would not increase for any plans above 130 percent of the national weighted-average premium.

Figure 3 graphically displays how these breakpoints would interact with premiums.

² The national weighted-average premium is calculated using plan's premiums weighted by the percentage of the total Medicare population enrolled in each of the plans. The current FPS plan, with approximately 85 percent of Medicare's enrollment, would be the dominant actor in determining the weighted average premium, at least in the early years.

Figure 3 -Hypothetical Premium Support Using a Three Breakpoint Formula

Key to this type of contribution formula is where the initial X percent is set. Assuming that the current Medicare benefit package does not change, setting the contribution below the current levels helps address Medicare's long-term solvency crisis, but results in higher costs for beneficiaries. Setting the contribution higher than current levels would make a new program more attractive to beneficiaries, but might harm Medicare's chances of attaining financial solvency.

Again there are tradeoffs among competing goals. In FEHBP and other employment-based coverage the contribution is a lower percentage of an overall more comprehensive set of benefits. While the beneficiary premiums resulting from this type of formula might be larger than current Part B premiums, they would probably be less than the combined amounts beneficiaries pay for Part B and Medigap (about \$1,800 per year) or beneficiaries and their employers pay for Part

B and retiree coverage (about \$2,300 per year).³

B) Setting the contribution's growth rate in future years -

The key question in setting the level of government support after the first year is who is at risk if costs are higher than expected? In cases where the government holds the risk, there could be additional pressures to raise taxes or increase deficit spending. If the beneficiaries hold the risk, their out-of-pocket expenses could increase significantly.

The risk of increasing taxes or beneficiary out-of-pocket spending could be shared equally by allowing the government contribution to grow by the same percentage as plan premiums. Under this type of contribution, if average Medicare premiums went up 10 percent, both the government contribution and the average beneficiary premium would go up 10 percent. This would ensure that risk of future premium growth, as well as savings from prudent consumer behavior, are shared equally. This is the type of risk sharing currently found in the FEHBP, which has resulted in premium growth rates lower than both the private sector and Medicare over the last decade or so.

For the analysis presented in "Cost Estimate....", staff assumed that risk and saving would be shared equally, that is, the contributions would grow at the same rate as the weighted-average of actual premiums. All plans would be included in the calculation, including the traditional FFS plan.

C) Variations in the contribution -

The contribution could be varied based on the following factors:

1) **Risk** - The contribution could be risk adjusted to protect insurers from adverse selection and remove any disincentives for them to develop programs that

³ Together these two groups comprise over two-thirds of Medicare beneficiaries. Another 13 percent of non-institutionalized beneficiaries have Medicaid coverage and would not face any premium charges. Beneficiaries with Medicare FFS as their only coverage comprise about 10 percent of the Medicare population. Lower-income beneficiaries could receive a subsidized contribution that would offset possibly higher premiums. Higher income people who choose to keep FFS as their only coverage would face higher premiums.

would attract potentially high cost beneficiaries, e.g., disabled and chronically ill. The contribution could be adjusted for factors such as age, gender, health status, and other effective predictors of individual health expenses.

2) Income - A premium support system would include beneficiaries previously eligible for the QMB and SLMB programs. These beneficiaries might have a higher government contribution paralleling the old QMB and SLMB logic. For example, if higher income beneficiaries receive a contribution set at 75 percent of average premium costs, the SLMB eligibles might get 90 percent and QMB eligibles 100 percent. This should hold them harmless in noncompetitive markets and allow them a wide choice of plans in competitive markets. Table 1 (at the end of this paper) provides greater detail on assistance for low-income Medicare beneficiaries. (For the analysis presented in "Cost Estimate....", unless otherwise noted, staff assumed that the current QMB and SLMB programs continued to operate as under current law.)

3) Market Area - Whether the government contribution is linked to average Medicare plan premiums in the county, the metropolitan area, the nation, or some other area, depends on whether the government wishes to reflect the variation that exists across different regions of the country. The contribution might be adjusted for geographic differences such as local labor rates and local prices for goods and services, but not adjusted for variations such as differences in provider practice patterns or other unexplained utilization differences. To avoid some of the flaws of the old administered pricing system (e.g., paying too much in some counties and not enough in others), the contribution could be adjusted based on local market input prices. In this case, input prices refer to cost differences between markets due to the general cost of doing business in that market (e.g., wages, rent, supplies), not geographic differences in the practice patterns of Medicare providers. Staff assumed a national weighted government contribution for the analysis presented in "Cost Estimate....".

D) Building incentives for plans to offer coverage in underserved areas -

Other analysts have suggested that the government contribution itself should be calculated at the individual market level, rather than basing the contribution on the national weighted-average premium and simply adjusting the contribution based on local market input prices. The contribution displayed in "Cost Estimate...." has

not been designed in this way for a number of reasons:

One, there was concern that in markets with only one or two plans the government contribution might fluctuate widely from year to year.

Two, one of the attractive aspects of the FEHBP program is its ability to offer multiple plans in every market in the country. In 1998, FEHBP had seven insurers offering 10 different plan options nation-wide. Under the current Medicare program, Medicare+Choice plans have been criticized for failing to successfully penetrate rural markets. Beneficiaries in rural areas seldom have any choice other than the traditional FFS plan. For lower-income beneficiaries, who cannot afford Medigap coverage, the outlook is bleak. The presence of a variety of national plans is more likely if plans can bid one national premium and know the contribution will be adjusted for the mix of markets, than if plans had to bid 100 or more premiums for every different market in the country.⁴ A middle position would be to allow plans to offer coverage regionally. This might offer greater access to mid-sized insurers who would hesitate to offer national coverage.

Conclusions

The options discussed in this paper are intended to provide Commissioners with a feel for the options available under a premium support system. There are other ways that benefits, contributions, and other aspects of the program could be designed. The options offered here are an attempt to focus the discussion, without limiting possibilities.

⁴ In FEHBP there are three categories of plans defined in the statute, service benefit, indemnity plans (i.e., large FFS/PPO), employee association plans (e.g., Mailhandlers) and pre-paid plans (i.e., HMOs). In order to participate the large FFS/PPO plans have to offer coverage nation-wide. Both the service benefit/indemnity and employee association plans have to bid national premiums to participate in the program.

UPDATE ON MEDICARE COMMISSION

November 23, 1998

MEMBERS (Who appointed them):

John Breaux, Chair (Consensus)	Jay Rockefeller (Daschle)
Bill Thomas, Co-Chair (Gingrich)	Michael Bilirakis (Gingrich)
Stuart Altman (President)	Samuel Howard (Gingrich)
Laura D'Andrea Tyson (President)	Colleen Conway-Welch (Gingrich)
Bruce Vladeck (President)	Bill Frist (Lott)
Tony Watson (President)	Illene Gordon (Lott)
John Dingell (Gephardt)	Phil Gramm (Lott)
Jim McDermott (Gephardt)	Deborah Steelman (Lott)
Bob Kerrey (Daschle)	

SCHEDULE:

March 6:	Opening Statements
April 22-23:	Panels with Speakers (e.g., Greenspan, Third Millennium, etc)
June 1-2:	Panels with Questions / Discussion
July 13:	Minneapolis Site Visit
August 10:	GME Panel and Task Force Meetings
September 8-9:	Day one is for "Call for Solutions"; Day two was closed door meeting to try to decide what's the "problem"
October 5-6:	Closed door meeting to begin discussing options
December 2-3:	Public and private meeting to discuss options
January: 5	Final recommendations
February:	Report (due on March 1, 1999)

OUTLINE OF COMMISSION WORK PLAN

The Commission has divided its work into three parts to date:

- **What is the problem:** There has been considerable discussion of the uncertainty of projected expenditures and the influence of factors such as health and technology. There has also been debate about whether Medicare's problems are only fiscal or whether they include its inadequate benefits, inequitable payment rates by region, etc.
- **Reform options** (otherwise known as traditional types of policies or "incremental reform"): This consists of a wide range of policy options that have to do with the way Medicare pays non-managed care providers:
- **Restructuring options** ("start from scratch" proposals): To date, the primary focus of the restructuring options is a "premium support" model, which usually means a defined contribution / defined benefit model. Interestingly, most of the discussions have assumed that there would be a fixed, minimum benefit, and most agree that it should include prescription drugs. The two issues that are controversial are how much does the government pay, how much do beneficiaries pay, and does traditional Medicare remain an option.

DRAFT

PRINCIPALS TO GUIDE THE MEDICARE COMMISSION RECOMMENDATIONS

Any Medicare proposal should:

- **Adopt private sector, competitive practices:** Historical, statutory, and regulatory barriers prevent Medicare from adopting some of the successful payment policies used by private health plans to control health costs. Any proposal should allow and encourage the Health Care Financing Administration to adopt such practices to better contain costs.
- **Align Medicare per capita cost growth with the private sector rate:** The rate of growth of private sector health care costs takes into account both the unique effects of technology on health costs and the cost control achieved through innovative practices. Even though Medicare beneficiaries are sicker and more difficult to manage than privately insured people, private health spending growth should be a goal of any Medicare reform proposal.
- **Guarantee a minimum, modernized benefits package:** Today's Medicare benefits are more similar to private plans in the 1960s rather than the 1990s. For example, while most private plans today offer prescription drug coverage, Medicare does not. Additionally, Medicare has high cost sharing for certain benefits and does not offer protection against catastrophic health care costs. As a result, the majority of beneficiaries rely on other types of coverage (e.g., Medigap, employer plans, Medicaid), resulting in inefficiency and high out-of-pocket costs. Any reform proposal should both guarantee a basic set of health benefits and modernize those benefits to lessen the need for secondary health coverage.
- **Assure access to Medicare fee-for-service coverage:** While over 80 percent of privately insured people are enrolled in managed care, only 16 percent of Medicare beneficiaries are so enrolled. In part, this is because Medicare beneficiaries are older and more likely to be sick -- thus less likely to benefit from managed care. It may also reflect the lack of plan choices for beneficiaries; one in four beneficiaries today lives in a place with no private managed care option, and only about half have more than one plan to choose from. This year, Medicare is allowing a greater variety of plans to offer coverage, but to date, it has not resulted in a greater number of beneficiaries with choices. Thus, to ensure that Medicare beneficiaries have access to needed health care services, strong, modernized, more efficient Medicare fee-for-service coverage is essential to any reform proposal.
- **Protect low-income beneficiaries:** Nearly two-thirds of elderly households have income under \$20,000. Already, these elderly pay about one-third of their incomes on out-of-pocket health care costs. Thus, any proposal should assure that such beneficiaries pay no more -- and possibly less -- than they do under current law.

OUTLOOK FOR THE UNIFIED BUDGET

FOR THE NEXT DECADE SOCIAL SECURITY IS RESPONSIBLE FOR MOST OF THE UB SURPLUSES

Budget Projections						
	CBO July 1998 (Billions of dollars)			OMB Mid-session Review 1998 (Billions of dollars)		
	Unified Budget	Non-Social Security	Social Security	Unified Budget	Non-Social Security	Social Security
1998	63	-41	104	39	-63	102
1999	80	-37	117	54	-59	113
2000	79	-46	125	61	-62	123
2001	86	-45	131	83	-48	131
2002	139	1	138	148	6	142
2003	136	-10	146	150	-2	152
2004	154	0	154	184	24	160
2005	170	5	165	213	36	177
2006	217	44	173	245	60	185
2007	236	55	181	300	103	197
2008	251	64	187	342	136	206
1999- 2008	1548	31	1517	1780	194	1586

Table 6 -- Estimated financial effects of alternative proposals to increase the HI tax rate for employers and employees, each, by a specified percentage

	Increase the employer/employee payroll tax rate by ...				
	Present law	0.25%	0.50%	0.75%	1.00%
A. Actuarial Balance (percentage of taxable payroll)					
1998-2022.....	-0.73%	-0.25%	0.23%	0.71%	1.18%
1998-2047.....	-1.61%	-1.13%	-0.64%	-0.15%	0.33%
1998-2072.....	-2.10%	-1.61%	-1.12%	-0.64%	-0.15%
B. Increase in payroll tax revenues (in billions)					
1999.....	-	\$16	\$32	\$49	\$65
2000.....	-	23	45	68	90
2001.....	-	24	47	71	94
2002.....	-	25	49	74	98
2003.....	-	26	51	77	103
2004.....	-	27	54	81	108
2005.....	-	28	57	85	113
2006.....	-	30	60	90	119
2007.....	-	31	63	94	126
1999-2003.....	-	114	224	339	450
1999-2007.....	-	230	458	689	916
C. Trust Fund Ratio (assets at beginning year as a % of annual expenditures)					
1999.....	73%	73%	73%	73%	73%
2000.....	68%	84%	99%	115%	130%
2001.....	63%	94%	125%	156%	187%
2002.....	58%	104%	151%	198%	245%
2003.....	53%	114%	176%	238%	301%
2004.....	46%	121%	198%	275%	352%
2005.....	37%	127%	218%	309%	400%
2006.....	27%	131%	236%	341%	446%
2007.....	16%	134%	252%	371%	489%
2010.....	(*)	133%	290%	447%	605%
2015.....	(*)	97%	310%	524%	737%
2020.....	(*)	20%	279%	538%	797%
2025.....	(*)	(*)	195%	490%	784%
2030.....	(*)	(*)	73%	402%	730%
2035.....	(*)	(*)	(*)	292%	659%
2040.....	(*)	(*)	(*)	166%	582%
2045.....	(*)	(*)	(*)	27%	502%
2050.....	(*)	(*)	(*)	(*)	415%
2055.....	(*)	(*)	(*)	(*)	319%
2060.....	(*)	(*)	(*)	(*)	208%
2065.....	(*)	(*)	(*)	(*)	81%
2070.....	(*)	(*)	(*)	(*)	(*)
D. Year of trust fund depletion.....					
	2008	2020	2032	2045	2068
E. Board of Trustees tests:					
Short range test.....	No	Yes	Yes	Yes	Yes
Long-range test.....	No	No	No	No	Yes

* Fund is depleted.

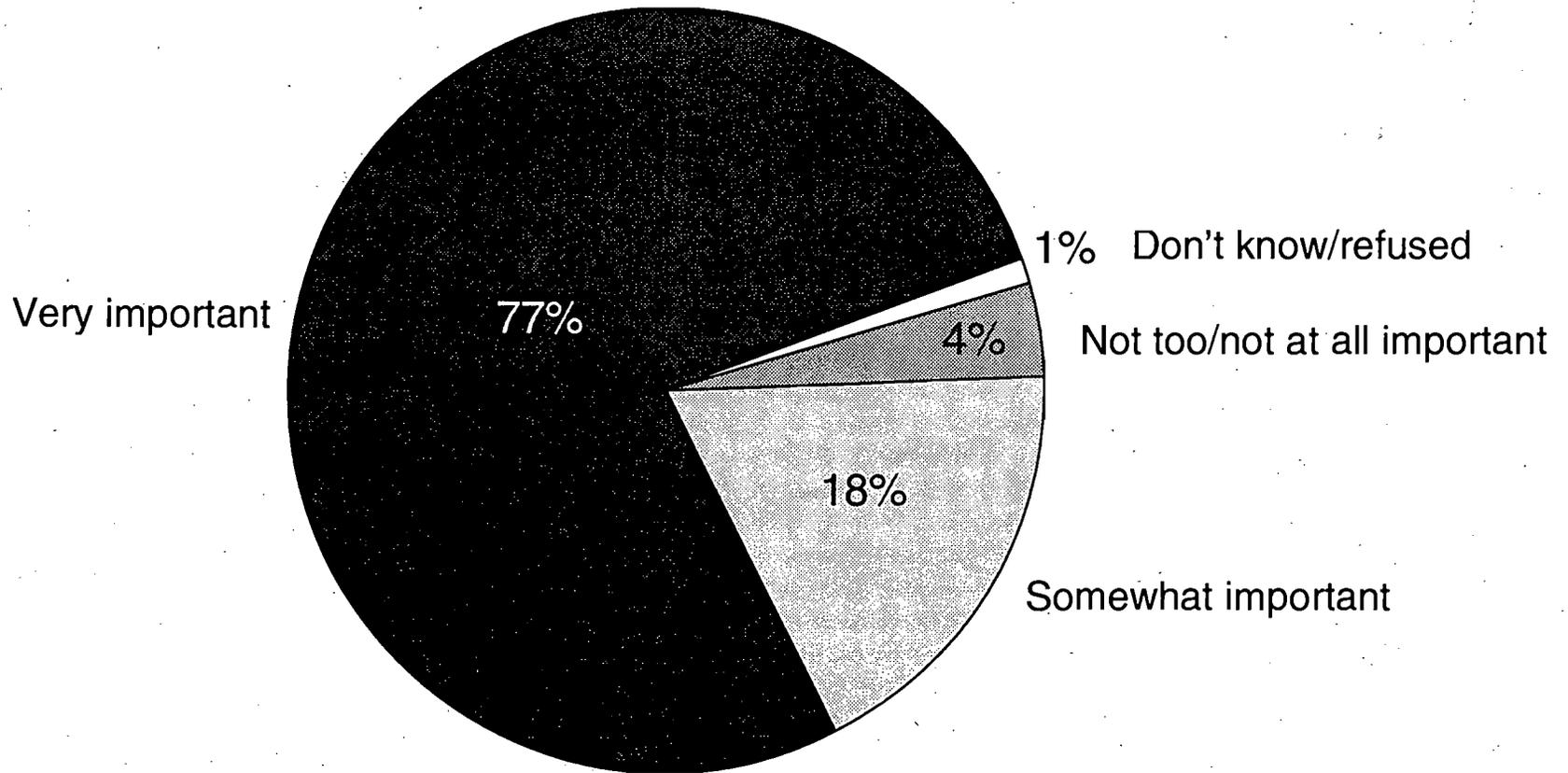
- Note 1. The above estimates are based on the intermediate set of assumptions from the 1998 Trustees Report.
 2. Illustrative proposals are assumed to take effect starting in 1999.
 3. All years shown are calendar years.
 4. The Board of Trustees tests are complex. Complete definitions of these tests are available in the Glossary of the 1998 HI Trustees Report.

Office of the Actuary
 Health Care Financing Admin.
 May 14, 1998

Chart 1

AMERICANS WANT TO PRESERVE MEDICARE

Percent who say how important it is that Medicare is preserved as a health care program for all people when they retire...

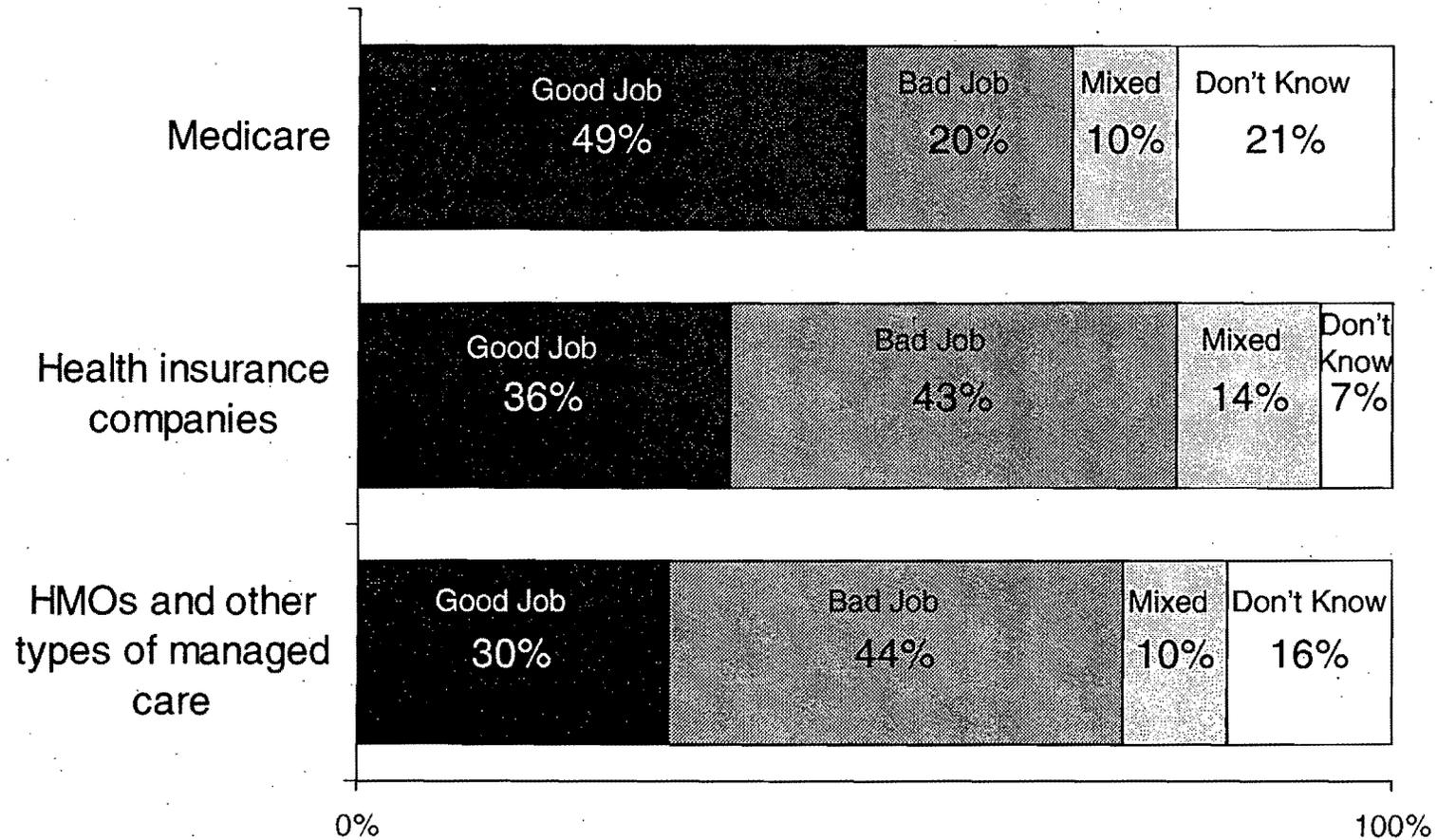


Source: Kaiser Family Foundation/Harvard School of Public Health National Survey on Medicare, October 20, 1998 (conducted Aug-Sept 1998).

Chart 3

MEDICARE RATED MORE FAVORABLY THAN OTHER TYPES OF HEALTH INSURANCE

Percent who say what kind of job each does serving health care consumers...

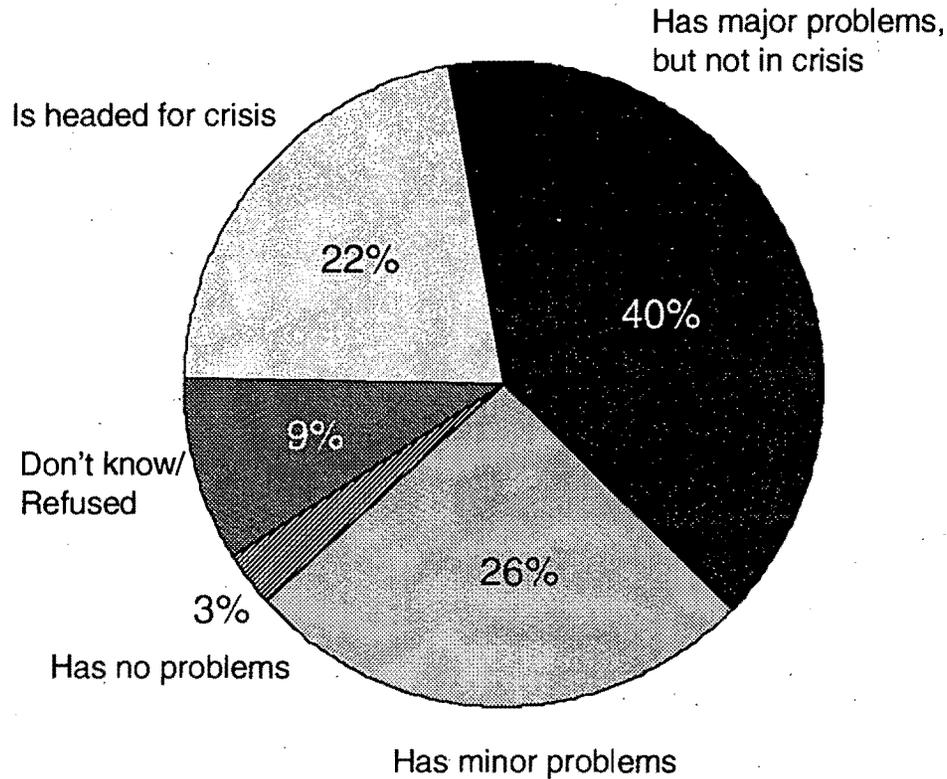


Source: Kaiser Family Foundation/Harvard School of Public Health National Survey on Medicare, October 20, 1998 (conducted Aug-Sept 1998).

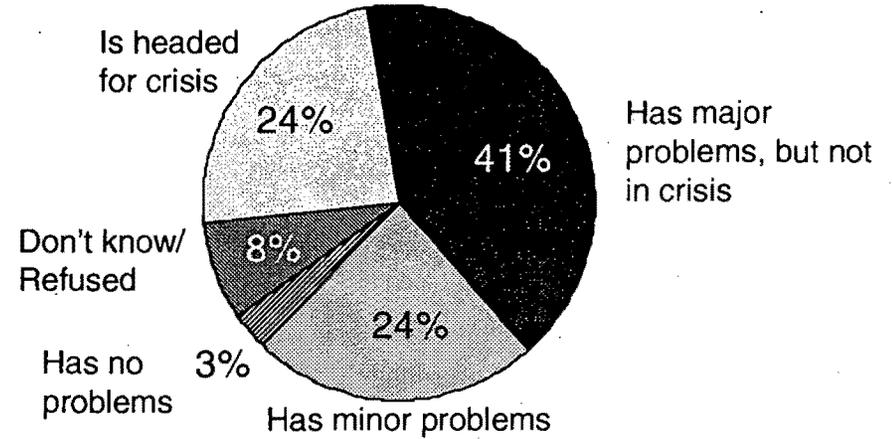
AMERICANS THINK THE MEDICARE PROGRAM FACES PROBLEMS

Percent who say Medicare...

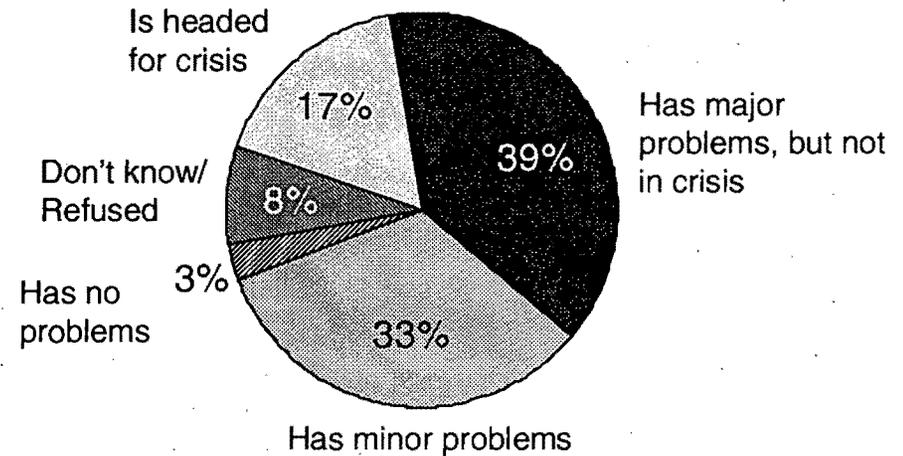
TOTAL



UNDER 65



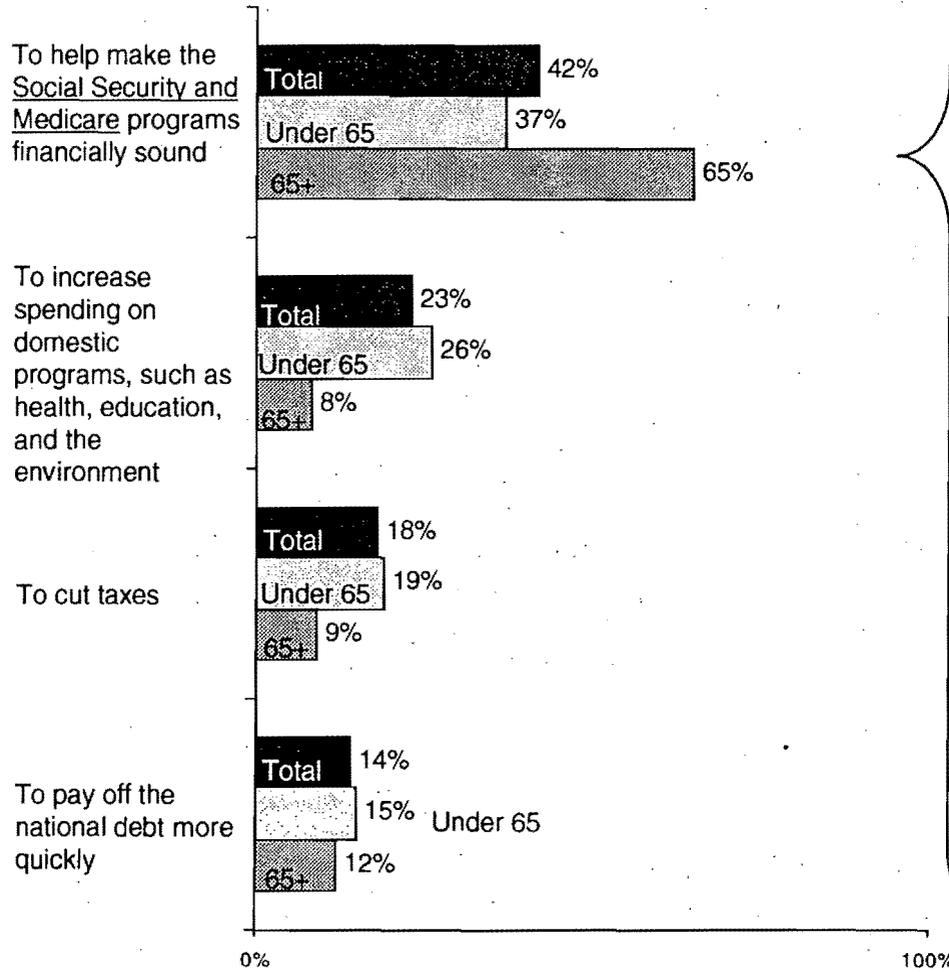
65+



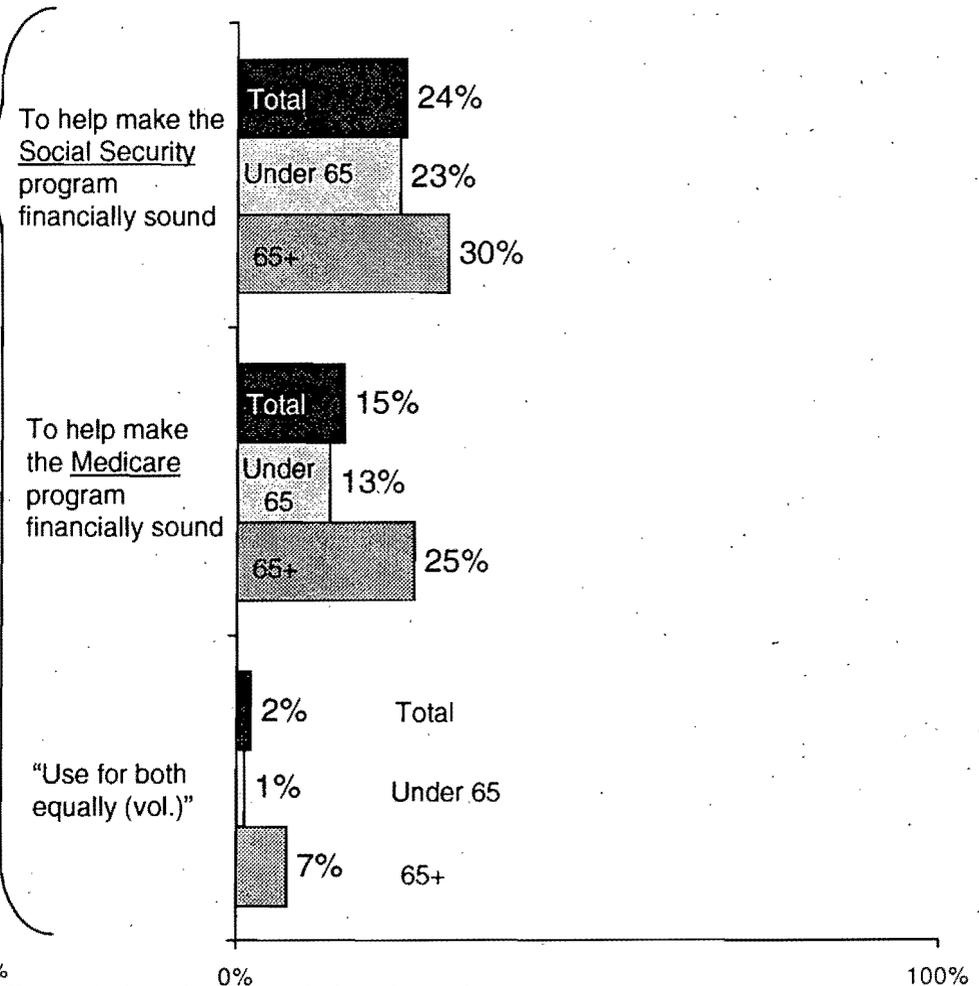
Source: Kaiser Family Foundation/Harvard School of Public Health National Survey on Medicare, October 20, 1998 (conducted Aug-Sept 1998).

MANY AMERICANS SAY GOVERNMENT BUDGET SURPLUS SHOULD BE USED TO BOOST SOCIAL SECURITY AND MEDICARE

Percent who say surplus should be used...



When forced to choose between Social Security and Medicare, percent who say surplus should be used...

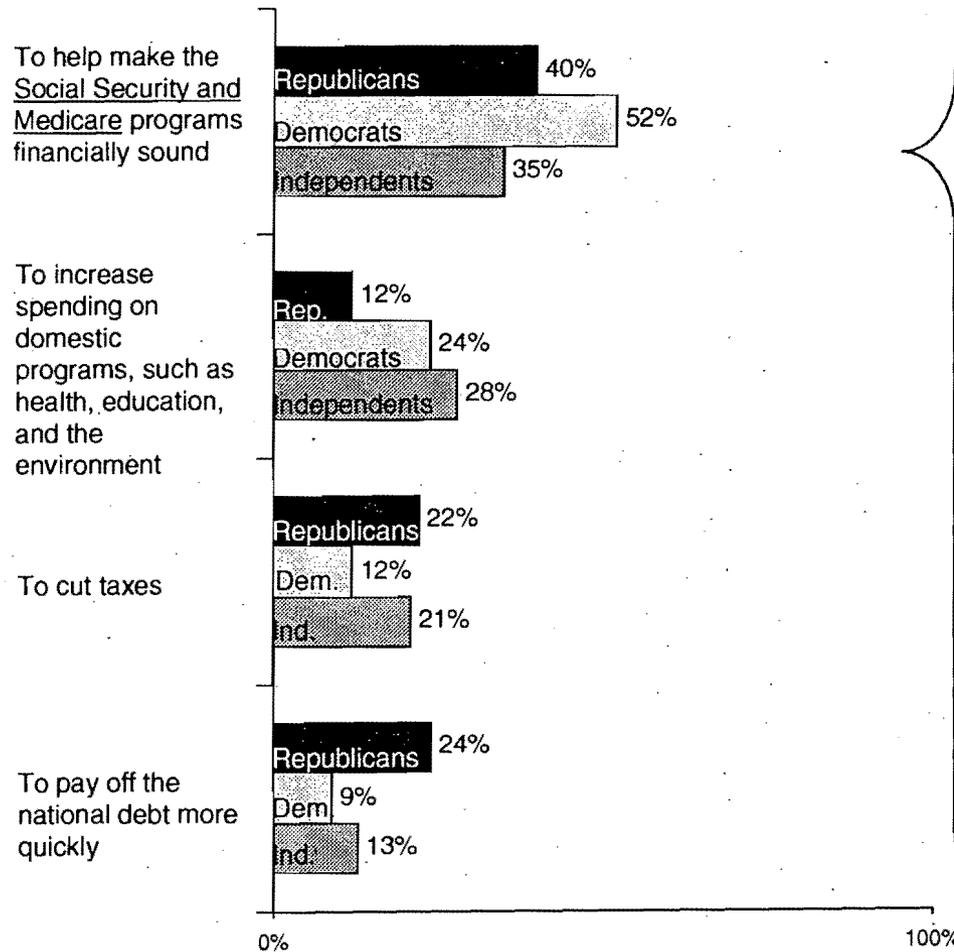


Note: "VOL" means response was volunteered by respondent, not an explicitly offered choice; don't know/refused not shown.

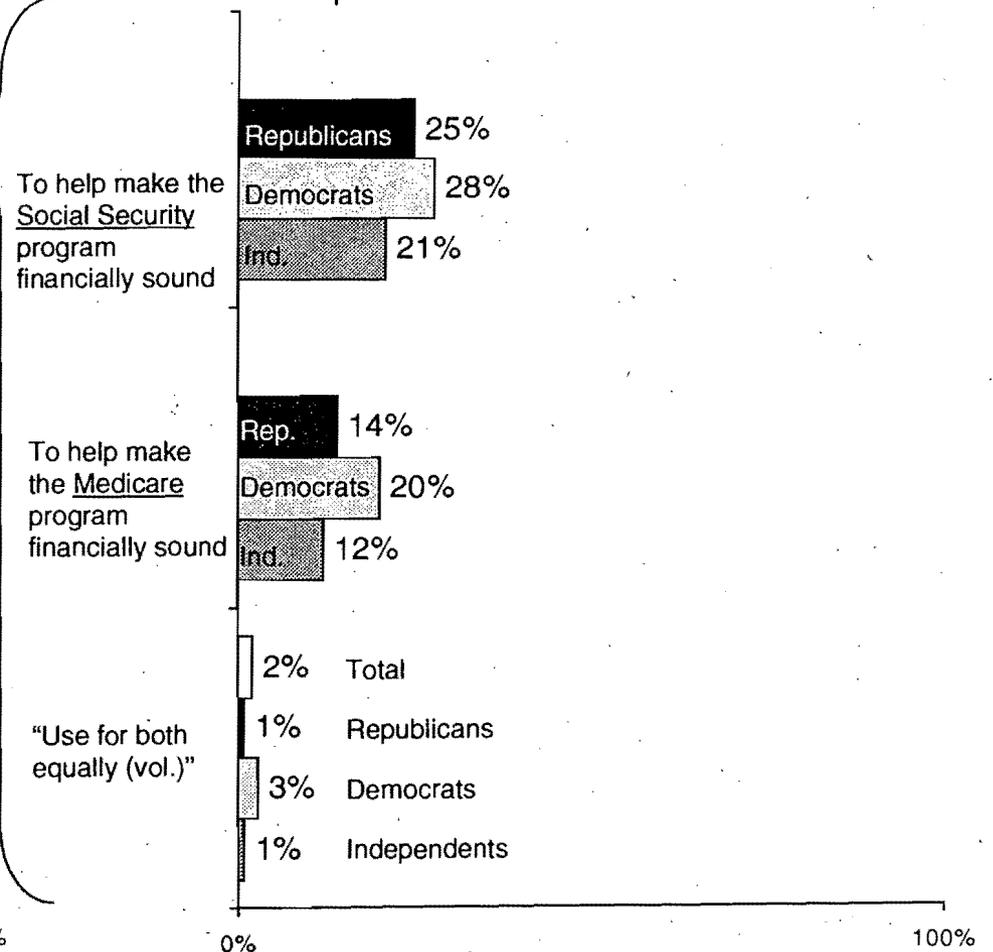
Source: Kaiser Family Foundation/Harvard School of Public Health National Survey on Medicare, October 20, 1998 (conducted Aug-Sept 1998).

DEMOCRATS MORE LIKELY THAN REPUBLICANS TO WANT TO USE SURPLUS TO BOOST SOCIAL SECURITY AND MEDICARE

Percent by political party who say surplus should be used...



When forced to choose between Social Security and Medicare, percent by political party who say surplus should be used...



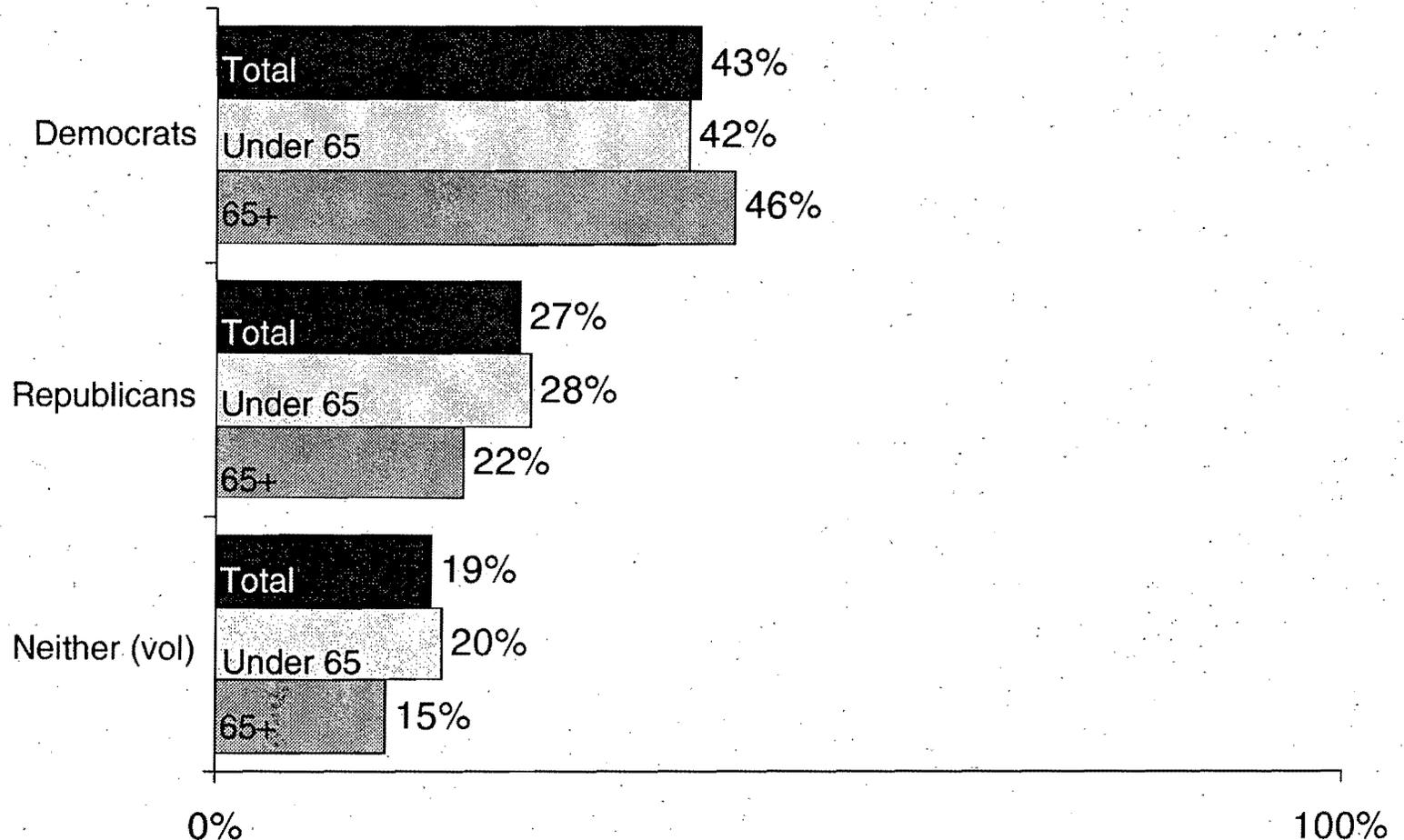
Note: "VOL" means response was volunteered by respondent, not an explicitly offered choice; don't know/refused not shown.

Source: Kaiser Family Foundation/Harvard School of Public Health National Survey on Medicare, October 20, 1998 (conducted Aug-Sept 1998).

Chart 7

MORE AMERICANS TRUST DEMOCRATS THAN REPUBLICANS TO DEAL WITH THE PROBLEMS FACING MEDICARE

Percent who say they trust Democrats or Republicans more to deal with problems facing Medicare...

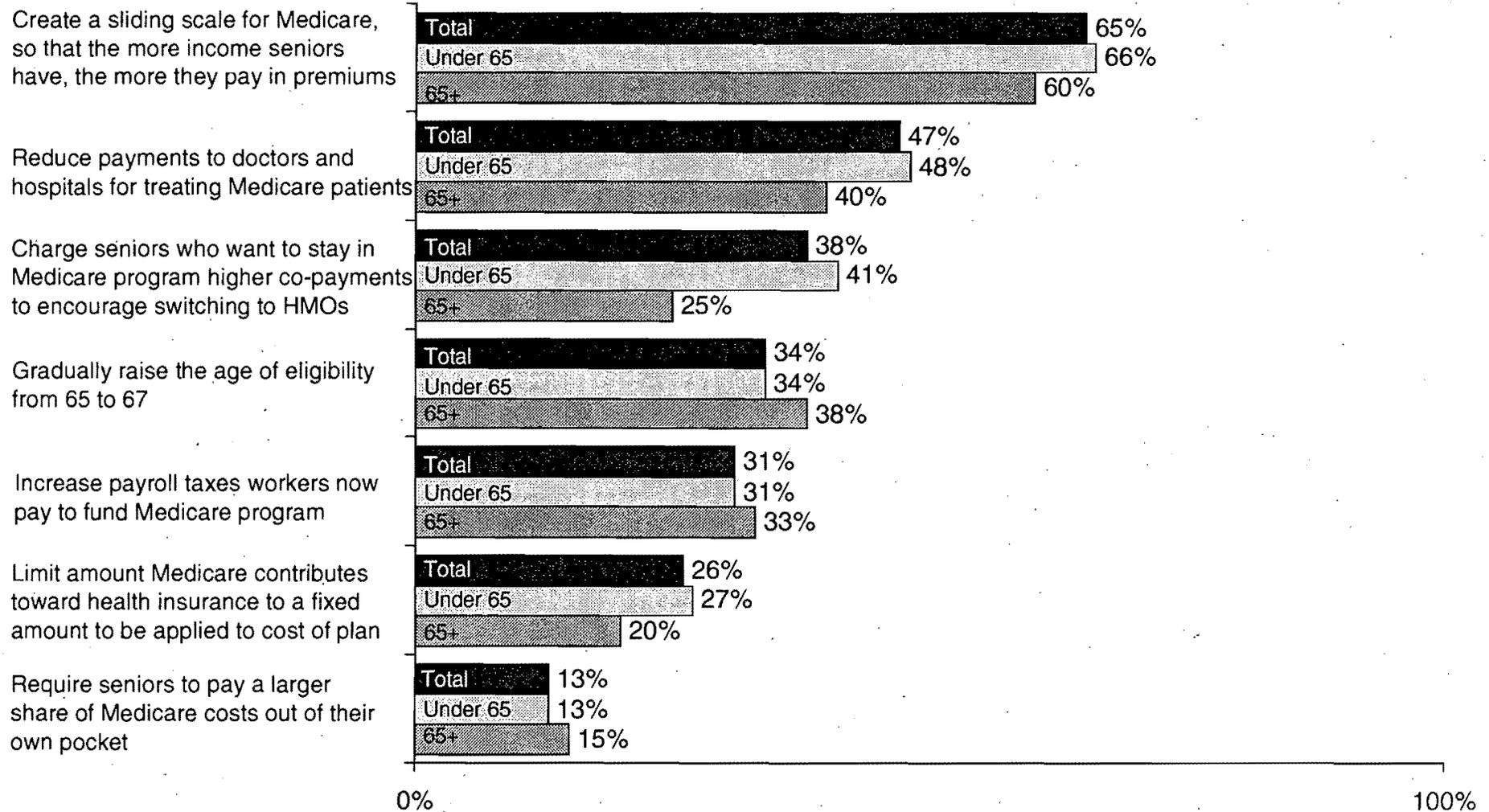


Note: "VOL" means response was volunteered by respondent, not an explicitly offered choice; don't know/refused and both equally (vol.) not shown.

Source: Kaiser Family Foundation/Harvard School of Public Health National Survey on Medicare, October 20, 1998 (conducted Aug-Sept 1998).

...BUT AMERICANS NOT READY TO MAKE HARD CHOICES TO ADDRESS MEDICARE'S FISCAL PROBLEMS...

Percent who favor each proposal when arguments for and against are presented...



Source: Kaiser Family Foundation/Harvard School of Public Health National Survey on Medicare, October 20, 1998 (conducted Aug-Sept 1998).

**Medicare Part A Trust Fund Scenarios
Based on May 14, 1998 Memo**

	Revenue 0.25% Incr	% Unified Surplus	Revenue 0.50% Incr	% Unified Surplus
1999	16	30%	32	59%
2000	23	38%	45	74%
2001	24	29%	47	57%
2002	25	17%	49	33%
2003	26	17%	51	34%
2004	27	15%	54	29%
2005	28	13%	57	27%
2006	30	12%	60	24%
2007	31	10%	63	21%
1999-2003	114		224	
1999-2007	230		458	
Year of TF	2020		2032	

622-1100

Wendy - money -- new activities

- India - problem

- Africa - more opportunities & innovations

Africa

Agenda for Meeting on Relationship between Medicare Commission & Social Security

1. Why now

Connections between Social Security and Medicare Debates

POTUS

Breaux: Memo to the VP, National Journal, talk show
Freshmen Democrats

Medicare Commission next week

Dingell, others looking for guidance

Unified 1.5 trillion

Pain Free

(Investing // Surplus)

{Medicare}

2. Social Security

• Solutions to Social Security will have implications on Medicare (and vice versa)

- Funding issues (e.g., use of the surplus, payroll tax, privatization)

- Age eligibility changes

Medicare premiums, Medicaid and Social Security

- Allocation of responsibility between government & beneficiaries (e.g., private accounts, long-term care)

- Population groups (e.g., disability, women and minorities)

• What analysis to do re surplus / Medicare?

• How to respond to questions surrounding Conference, budget and Commission?

3. Short and long-term guidance for Medicare Commission

o Areas of consensus: drugs, Parts A and B

o Controversial areas: Premium support / FEHBP, GME?

o What should be our message at the public meeting, Democrats only meeting?

o How do we get guidance on end-run strategy?

SC
Medicare
Commission

MEDICARE REFORMS

Fee-For Service

- Competitive pricing
- Cost sharing rationalization
- Program integrity
- Post-acute and chronic care management
- BBA extenders

Managed Care

- Competitive pricing
- Redefining geographic areas
- HMO withdrawals
- Risk adjustment
- Standardizing supplemental benefits

Other

- Prescription drugs
- Merging Parts A and B
- Income-related premium
- GME
- Low-income protections

Lawrence

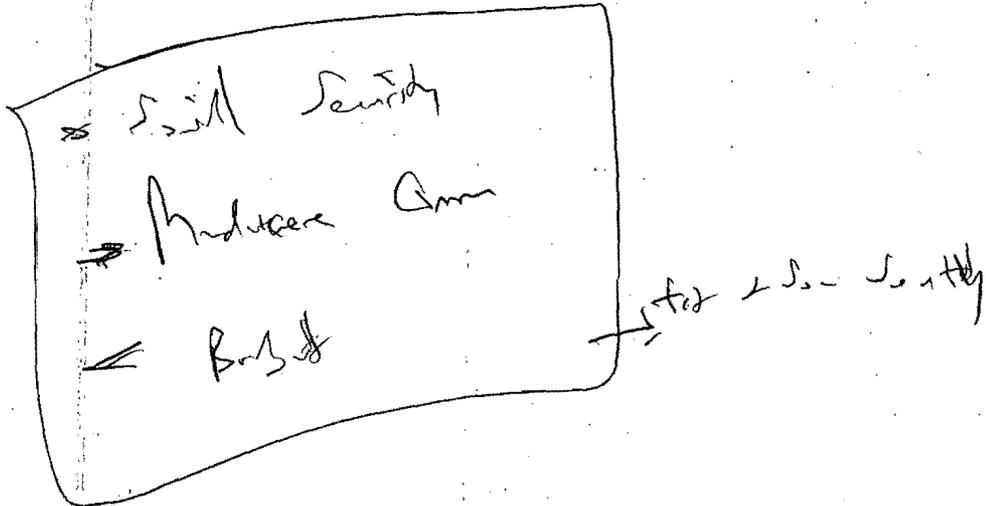
Net. Avg weights ~~at~~ present

Avg. winter. All sold + extra market

~~Gene Spelling~~ since 90%

\$ 5,000

DJ



DRAFT

PRINCIPALS TO GUIDE THE MEDICARE COMMISSION RECOMMENDATIONS

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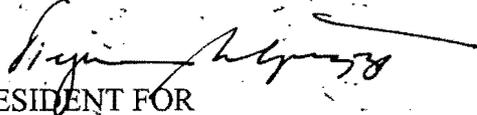
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THE WHITE HOUSE

WASHINGTON

December 8, 1998

MEMORANDUM FOR ALL EOP STAFF

FROM: VIRGINIA M. APUZZO 
ASSISTANT TO THE PRESIDENT FOR
MANAGEMENT AND ADMINISTRATION

SUBJECT: Opening of Passholder Entry/Exit Gate

Effective immediately, the Secret Service pedestrian gate at the north end of West Executive Avenue will be open 24 hours a day, 7 days a week as an entry and exit gate for orange and blue passholders. This gate has recently been upgraded with the same technology as other entry gates to include the access control pad for passholders to scan their passes for entry and exit. It is accessible to wheelchair users and others with mobility related disabilities. The vehicle gate on the north end of West Executive Avenue will remain closed.

The north gate is also equipped to provide "T" badges to passholders who forget their pass. As a reminder, passholders must present photo identification to obtain a temporary pass for the day.

Please call Management and Administration at x62861 with any questions. Thank you.

To TAKE HOME:

① Drug SPECS -
Please decide
ON BOLD
ITEMS.

② MANDATORY - ATTACH -
please give me
guidance

③ HAVE INSIGHT ON MCR
OFFSETS - To Discuss.

Suggested Revision to Administration Cost Sharing / Drug Specs, 12/8

Cost Sharing:

Deductible:	\$250 indexed to general inflation
Coinsurance:	20%
Hospital:	None
OPD:	Current law
Preventive:	None
Home Health:	10%
SNF:	20%
Mental Health:	Current law
Out-of-pocket limit:	None
Medigap:	Prohibited for deductible

Drug Specs:

Deductible:	\$250 (Medigap) or None (HMOs)
Copayments:	Model after [fix some plan? FEHBP?]
Out-of-pocket limit:	None (Medigap, HMOs)
Payment limit:	\$1,250 - 3,000 (Medigap); Medicare HMOs:
	None: 40 percent of enrollees
	< \$1,000: 24 percent
	\$1,000: 17 percent
	> \$1,000: 19 percent

Medigap: Prohibited from covering drugs or deductible

Management:	FFS:
	Opt. 1: PBMs, based on competitive bidding
	Opt. 2: National formulary
	Opt. 3: [other?]

Managed Care: Whatever / allow them to compete

Premiums:	Assume that:
	- Voluntary for FFS, mandatory for managed care
	- Beneficiaries pay:
	Opt. A: Full cost
	Opt. B: 75 percent of cost

Prescription Drug Benefits

What is covered

You may purchase up to a 90-day supply of the following medications and supplies prescribed by a doctor from either a pharmacy or by mail; however, quantities may be limited for certain drugs such as narcotics:

- Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a doctor's prescription for their purchase
- Insulin
- Needles and disposable syringes for the administration of covered medications
- Intrauterine devices (IUDs), Norplant, Depo-Provera, and oral contraceptives dispensed by a retail pharmacy; and oral contraceptives obtained through the Mail Service Program
- Drugs to aid smoking cessation that require a prescription by Federal law (limited to one regimen per calendar year)

You can save money by using generic drugs. By submitting your prescription (or those of family members covered by the Plan) to your retail pharmacy or the Mail Service Prescription Drug Program, you authorize them to substitute a Federally approved generic equivalent, if available, unless you or your physician specifically requests a name brand.

What is not covered

- Medical supplies such as dressings and antiseptics
- Drugs and supplies for cosmetic purposes
- Medication that does not require a prescription under Federal law even if your doctor prescribes it or a prescription is required under your State law
- Drugs prescribed for weight loss
- Drugs for orthodontic care, dental implants, and periodontal disease
- Drugs for which prior approval has been denied

From a pharmacy

You may purchase up to a 90-day supply of covered drugs and supplies through the Retail Pharmacy Program. Call 1-800/624-5060 (TDD: 1-800/624-5077) to locate a Preferred pharmacy in your area.

	High Option	Standard Option
PPO/Preferred retail pharmacies	After you pay the \$50 prescription drug deductible, Plan pays 85% PPA	After you pay the \$50 prescription drug deductible, Plan pays 80% PPA
Non-preferred retail pharmacies	After you pay the \$50 prescription drug deductible, Plan pays 65% of the Billed charge	After you pay the \$50 prescription drug deductible, Plan pays 60% of the Billed charge

You must present your Plan ID card at the time of purchase at a Preferred pharmacy and pay 100% of the PPA up to the \$50 prescription drug deductible (\$100 per family; see page 9). After satisfaction of the \$50 deductible, you are only responsible for the appropriate coinsurance at the time of purchase. All Preferred retail pharmacies will file claims for you. Preferred pharmacies will receive the payment and agree to accept 100% of the PPA as payment in full. At Non-preferred retail pharmacies, you must pay the full cost at the time of purchase and submit a claim. You are responsible for the \$50 drug deductible and the applicable coinsurance based upon Billed charges (but see "If provider waives your share" on page 10). The Billed charge must be no more than the pharmacy's normal retail charge. Certain prescription drugs and supplies may require prior approval (see page 33). Any savings received by the Carrier on the cost of drugs purchased under this Plan from drug manufacturers are credited to the reserves held for this Plan.

Waiver

When Medicare Part B is the primary payer, the \$50 prescription drug deductible under High and Standard Options and the 15% PPA when you use a Preferred retail pharmacy under High Option will be waived after you supply proof of your enrollment in Part B directly to the Plan (see page 44). If you use a Preferred retail pharmacy, you are required to pay 20% PPA under Standard Option (coinsurance is waived after you supply proof of your confinement in a nursing home). If you use a Non-preferred retail pharmacy, you are required to file a paper claim and pay 15% of the Billed charge under High Option and 40% of the Billed charge under Standard Option (reduced to 20% of the Billed charge when confined in a nursing home). The Billed charge must be no more than the pharmacy's normal retail charge.

Prescription Drug Benefits *continued*

To claim benefits	Use a retail prescription drug claim form for prescription drugs and supplies purchased at Non-preferred retail pharmacies. You may obtain these forms by calling 1-800/624-5060 (TDD: 1-800/624-5077). Follow the instructions on the form and mail it to the Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057.
By mail	<p>If your doctor orders more than a 21-day supply of covered drugs or supplies, up to a 90-day supply, you may order your prescription or refill by mail from the Mail Service Prescription Drug Program. Merck-Medco Rx Services will fill your prescription.</p> <p>You pay an \$8 copayment under High Option and a \$12 copayment under Standard Option for each prescription drug, supply, or refill you purchase through the Mail Service Program.</p>
Waiver	When Medicare Part B is the primary payer , and you use the Mail Service Prescription Drug Program, your copayment is waived after you supply proof of your enrollment in Part B directly to Merck-Medco Rx Services (see page 44).
To claim benefits	<p>The Plan will send you information on the Mail Service Prescription Drug Program. To use the Program:</p> <ol style="list-style-type: none">1) Complete the initial mail order form.2) Enclose your prescription and copayment.3) Mail your order to Merck-Medco Rx Services, P.O. Box 30492, Tampa, FL 33633-0144.4) Allow approximately two weeks for delivery. <p>Alternatively, your physician may call in your initial prescription at 1-800/262-7890 (TDD: 1-800/446-7292). You will be billed later for the copayment. After that, you may then call the same number to order your refill, and either charge your copayment to your credit card or have it billed to you later. You should allow approximately one week for delivery.</p>
Prior approval	Certain prescription drugs and supplies may require prior approval before they will be covered under this Plan, and prior approval must be renewed periodically. Call 1-800/624-5060 (TDD: 1-800/624-5077) to obtain an updated list of prescription drugs and supplies that require prior approval. Once prior approval has been obtained or renewed, you may take advantage of electronic claims processing at Preferred pharmacies, have claims paid for drugs and supplies purchased from Non-preferred pharmacies, or have drugs and supplies dispensed by the Mail Service Program.
Retail Pharmacy Program	The Retail Pharmacy Program will request the medical evidence needed to make its coverage determination. Drugs and supplies that require prior approval also require 1) payment in full at time of purchase (including Preferred pharmacies) and 2) the member's submission of the expense(s) on a claim form. Preferred pharmacies will not file these expenses for you.
Mail Service Program	Merck-Medco Rx Services will screen all prescription drugs prior to dispensing. If the drug or supply requires prior approval, your prescription will not be filled until prior approval has been obtained. The prescription will be returned to you along with a Prior Approval Request form and a letter explaining the program and procedures.
Drugs from other sources	Prescription drugs and certain supplies not purchased from a retail pharmacy or through the Mail Service Program are covered at Other Medical Benefits levels when billed for by an outpatient facility or a physician (see pages 25 and 26), or Additional Benefits levels when billed for by a covered home health care agency (see page 30) or home hospice agency (see page 31). When hospitalized, drugs and supplies are covered under Inpatient Hospital Benefits (see page 16) or Maternity Benefits (see page 21).
Purchasing drugs when you are overseas	Claims for covered prescription drugs and supplies purchased outside of the United States and Puerto Rico should be submitted on an Overseas Claim Form and sent to the Overseas Claims Section address listed on page 37. Prescription drugs requiring constant refrigeration cannot be shipped to APO/FPO boxes by the Mail Service Prescription Drug Program.
Coordinating with other drug coverage	When you use a Preferred retail pharmacy and this Plan is the primary payer, you must call the Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program at 1-800/624-5060 (TDD: 1-800/624-5077) to request a statement of benefits for other coverage purposes.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Protection Against Catastrophic Costs

Catastrophic protection

For services with coinsurance or copayments (other than those shown below as excluded from this Catastrophic Protection Benefit), the Plan pays **100%** of its Covered charges for the remainder of the calendar year if out-of-pocket expenses for certain coinsurance, copayments, the calendar year deductible, prescription drug deductible, and per admission deductibles in that calendar year exceed \$2,700 (**High Option**) or \$3,750 (**Standard Option**) for you and any covered family members.

Preferred providers

When your eligible out-of-pocket expenses, as discussed above, from using Preferred providers (when the services are eligible to be received from Preferred providers) exceed \$1,000 (**High Option**) or \$2,000 (**Standard Option**), the Plan pays **100%** of its Covered charges for covered expenses when you continue to select Preferred providers for the remainder of the calendar year. Whether or not you use Preferred providers, your share of out-of-pocket expenses will not exceed \$2,700 (**High Option**) or \$3,750 (**Standard Option**) in a calendar year.

Out-of-pocket expenses

Out-of-pocket expenses for the purposes of this benefit are:

- The calendar year deductible of \$150 (**High Option**) or \$200 (**Standard Option**) and the \$50 prescription drug deductible under **High** and **Standard Options**;
- The per admission deductible of \$100 (**High Option**) or \$250 (**Standard Option**) you pay for inpatient Non-preferred hospital care;
- The \$10 (**High Option**) and \$25 (**Standard Option**) copayments that you pay for outpatient facility care and outpatient facility surgical care in Preferred facilities under Other Medical Benefits;
- The \$50 (**High Option**) and \$100 (**Standard Option**) copayments that you pay for outpatient facility care and outpatient facility surgical care in Member facilities under Other Medical Benefits;
- The 5% PPA coinsurance (under **High** and **Standard Options**) you pay for care provided by Preferred physicians, the 20% PAR (**High Option**) and 25% PAR (**Standard Option**) coinsurance you pay for care provided by Participating physicians, and the 20% NPA (**High Option**) and 25% NPA (**Standard Option**) coinsurance you pay for care provided by Non-participating physicians and other covered professionals under Inpatient Hospital Benefits, Surgical Benefits, Maternity Benefits, and Other Medical Benefits;
- The \$10 copayment (under **High** and **Standard Options**) that you pay for each home and office visit, physician's outpatient consultation, and second surgical opinion when provided by a Preferred physician under Other Medical Benefits, Physician care, or each preventive (screening) physical examination when provided by a Preferred physician or Preferred facility under Additional Benefits, Preventive services provided by Preferred providers; and
- The 15% PPA (**High Option**) and 20% PPA (**Standard Option**) coinsurance you pay for pharmacy-obtained drugs when provided by a Preferred pharmacy, and 35% of Billed charges (**High Option**) and 40% of Billed charges (**Standard Option**) coinsurance you pay for pharmacy-obtained drugs when provided by a Non-preferred pharmacy under Prescription Drug Benefits.

The following expenses are not included under this Catastrophic Protection Benefit. They are not counted toward eligible out-of-pocket expenses and are not payable by the Plan when the Catastrophic Protection Benefit out-of-pocket limits have been reached:

- Expenses in excess of Allowable charges or maximum benefit limitations;
- Mail Service Prescription Drug Program copayments;
- The 30% of the Non-member rate coinsurance you pay for Non-member inpatient facility care;
- The \$100 (**High Option**) and \$150 (**Standard Option**) copayments you pay for Non-member outpatient facility care;
- Expenses for Mental Conditions/Substance Abuse Benefits or Dental Benefits; and
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see pages 5, 41, and 42).

TABLE 1

Covered Benefits ¹	Standard Medigap Plans									
	A	B	C	D	E	F	G	H	I	J
Core Benefits *	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	✓	✓	✓	✓
SNF Coinsurance			✓	✓	✓	✓	✓	✓	✓	✓
Foreign Travel Emergency			✓	✓	✓	✓	✓	✓	✓	✓
At-Home Recovery				✓			✓			✓
Part B Deductible			✓				✓			✓
Part B Excess Charges						✓	a		✓	✓
Prescription Drugs								b	b	c
Preventive Medical Care					✓					✓
Enrollment Information²	A	B	C	D	E	F	G	H	I	J
Median Premium: 65-year-old ³	\$653	\$869	\$1,064	\$913	\$948	\$1,137	\$1,010	\$2,073	\$2,338	\$2,383
Percentage Distribution	10.9%	14.0%	25.6%	4.0%	1.1%	29.8%	1.1%	6.4%	2.0%	5.1%
Loss Ratio	109%	86%	84%	78%	88%	76%	73%	90%	81%	82%

Other facts

Total Number of Covered Lives in Standardized Plans = 6.1 million

Total Number of Covered Lives in Nonstandardized Plans = 5.8 million

Average Weighted Loss Ratio for Standardized Plans= 84.2%

Loss Ratio for Nonstandardized Plans= 81%

* Core benefits include Part A copayment for days 61-90 in the hospital, Part A copayment for each lifetime reserve day in the hospital, up to 365 additional days of hospital coverage after Medicare coverage is depleted, the first three pints of blood used under Part A or Part B, and the 20 percent coinsurance for Part B services after the Part B deductible has been met.

a Medigap policy pays 80 percent of balance billing charges

b After \$250 deductible, the policy covers 50 percent of prescription drug costs to a maximum of \$1,250.

c After \$250 deductible, the policy covers 50 percent of prescription drug costs to a maximum of \$3,000.

1 PPRC's 1997 "Annual Report to Congress," p. 320

2 1997 National Association of Insurance Commissioners' Medicare Supplement Data, unless otherwise noted, as tabulated by GAO. NOTE: This information was compiled but not independently verified by GAO. Therefore, this information is preliminary.

3 "Medicare: New choices, new worries," Consumer Reports, Sept. 1998

OTHER FACTS: 65% All BENE = Cover. Drug
 - 55% ALL HMO ENROLLERS
 86% BENE use presc. Drug
 Avg = \$600 exp/yr
 \$651 w/coverage
 432 w/o coverage
 458 = HMO

Drug Coverage in Medicare Risk Plans

This paper provides a descriptive analysis of drug coverage available to Medicare enrollees of risk HMOs and competitive medical plans during the 1998 contract year. The information is based primarily on the description of benefits included in the Medicare Compare data available through the "medicare.gov" Internet site. Enrollment information is based on the data included in the June, 1998, monthly report. Because not all plans appear in each data base, the analysis does not include information on 7 of the 322 risk plans operating as of the beginning of the 1998 contract year. However, the included plans represent 98% of enrollment as of June, 1998 (5.6 million out of 5.7 total). Most of the analysis of specific features of Medicare drug coverage in risk plans applies to plans offering drug coverage in all basic benefit packages—that is, the plans included in the analysis offer drugs to all enrollees, in all counties, at no extra cost. Except as otherwise noted, the analysis excludes drug coverage offered only to some enrollees as "flexible benefits" available in only some counties, or drug coverage offered only as supplemental benefits for which there is an additional premium charged. Other limitations of this analysis are described in detail in the appendix.

Coverage Information: General (All Plans)—Figure 1

Plans With Some Level of Drug Coverage

- ▶ There are 4.1 million beneficiaries enrolled in the 214 plans that include some level of drug coverage in the basic benefit package. That is, 72% of all Medicare risk plan enrollees are enrolled in plans that provide drug coverage to all enrollees as part of the basic benefit package.

Plans With No Drug Coverage or Drug Coverage Available only to Some Enrollees

- ▶ *No Drug Coverage or Coverage for Only Some Enrollees.* A minority of plans, representing 28% of total risk enrollment, do not include drugs in all basic benefit packages.
- ▶ *Coverage for Some Enrollees.* However, 19% of all risk enrollees (one million beneficiaries) are enrolled in 64 plans that (a) offer drugs to some enrollees through basic benefit packages available only in some portions of their service area, or (b) offer drug coverage as a supplemental benefit (i.e., the enrollee must purchase (or have his or her employer purchase or contribute towards) a separate premium for drug coverage.
- ▶ *No Drug Coverage.* Twelve percent of plans (37 plans) appear not to offer any type of drug coverage to Medicare risk enrollees. Only nine percent of risk enrollees are enrolled in such plans (one-half million beneficiaries).

Payment Levels and Drug Coverage (Figure 2)

- ▶ On average, the higher the level of Medicare capitation payments, the more generous a plan's drug coverage is likely to be.

Unlimited Drug Coverage—*Figure 3*

Drug Coverage with No Annual Dollar Limit

- ▶ 1.6 million beneficiaries enrolled in 35 plans (40% of all enrollees) have drug coverage for which there are no annual dollar limits (though cost-sharing and restrictions may apply, such as providing for unlimited coverage of generics but imposing dollar limits on brand-name drugs).
- ▶ Of the 35 plans, six plans, with 147,000 enrollees, have unlimited drug coverage (though some restrictions may apply) for which there are no copayments on any type of drug (i.e., four of these plans apply limits based on generic, brand, formulary, or mail order, but they do not require any copayments).
 - ▶ Among the six plans with no copayments, only one plan, a Florida plan with 24,000 enrollees, states that it offers unlimited drug coverage without restrictions. There are no copayments required in this plan, making it the only plan that appears to have completely unrestricted, free drug coverage.
 - ▶ Another Florida plan, with 16,000 enrollees, has no dollar limit on generic drugs and no dollar limit on brand-name drugs if generics are unavailable. This plan requires no copayments on drugs.
- ▶ The third largest plan in the country, with 211,000 enrollees, offers unlimited drug coverage for drugs purchased through its in-house pharmacy.
- ▶ The largest plan in the country, with over 400,000 enrollees, imposes no limits on generic drugs in any county of its service area, but, under HCFA's flexible benefits policy allowing county variation, the plan imposes a dollar limit on brand name drugs in two Southern California counties. For this plan, a total of 405,000 enrollees have unlimited generic and brand coverage, while the 36,000 enrollees in the two flexible benefit counties have brand limits.

Dollar Limits (*In Plans Offering Drugs in All Basic Packages*)—*Figure 3*

- ▶ Where an annual dollar limit is applied, the most common limit is \$1000 per year. Nearly one quarter of enrollees are members of the 48 plans with the \$1000 limit.

- ▶ About one-third of plans (with 24% of total enrollment) offering drug coverage in all basic packages have an annual dollar limit of less than \$1000.
- ▶ Dollar limits can vary by type of drug. There are 44 plans that have differential limits for brand versus generic drugs, and 20 plans that have different limits for formulary versus non-formulary drugs.

Cost Sharing (In Plans Offering Drugs in All Basic Packages)

Copayments—Figures 4, 5, 6

- ▶ *The great majority of plans require copayments for drug coverage.*

Figures 5 and 6 illustrate the levels of copayments among plans. In this analysis, a distinction is made between minimum and maximum copayments to recognize that the majority of plans have differing levels of copayments based on characteristics of the drugs being prescribed or how they are obtained (as in the example cited in the preceding paragraph, as well as differences based on mail order purchase, use of contracted pharmacies, etc.).

- ▶ A total of 56 plans, with 827,000 enrollees make a distinction in copayment levels based on whether a drug is a formulary or non-formulary drug. There are 122 plans, with 2.2 million enrollees, that require a higher copayment for non-generic, versus generic drugs.
- ▶ However, 56 plans, with 1.28 million enrollees, have a uniform level of copayment for covered drugs.

The highest level of copayment for a plan offering some form of no-dollar-limit drug coverage is the maximum \$50 per scrip charged by an Oregon plan (with 34,000 enrollees), which requires a 70% coinsurance on drugs up to the \$50 limit (with no annual maximum coverage for drugs obtained through the in-house pharmacy or elsewhere if included in the plan formulary). The 70%/\$50 maximum applies to all drugs for this plan.

The next highest level of copayments is among five plans (with a total of 75,000 enrollees) which require a \$30 copayment for brand-name, or brand non-formulary drugs.

Three plans, all in California, with 124,000 enrollees, require a \$25 copayment on brand or non-formulary drugs while charging \$5, \$7, and \$8 as the copayment for drugs not subject to the higher copayment.

Some plans have several levels of copayment. One plan, for example, requires a \$5 copayment for a 30-day supply of covered generic prescription drugs, a \$15 copay for brand-name drugs appearing on the plan formulary, and a \$30 copay for brand-name non-formulary drugs.

Deductibles

- ▶ Other than in the State of Wisconsin, where a State mandate determines the type of drug coverage (a \$6250 deductible and 20% coinsurance thereafter), only one plan requires a deductible to be met before coverage is provided. (In the State of Wisconsin, no plan offers drug coverage at a higher level than required by the State mandate, even though this is permissible.)

Coinsurance

- ▶ It is not common for Medicare risk plans to use coinsurance as a type of cost-sharing for drug coverage.

Only 16 plans (187,000 enrollees) apply coinsurance to drug coverage (including the four Wisconsin plans). Only three plans have coinsurance applicable to any type of drug (at 50%), but these plans have very limited coverage in general: the highest level of coverage is a \$400 annual limit on the amount to be reimbursed by the plan. Two other plans have across-the-board coinsurance but make a distinction between Medicare-covered (20%) and non-Medicare-covered (50%) drugs. These plans also have very limited coverage (\$500 and \$200 per year, with no limit permitted on Medicare-covered drugs).

Other plans make a distinction between generic (no coinsurance) and non-generic drugs. One plan specifies that there is a distinction based on a formulary applicable to all drugs. Two plans only cover drugs obtained through in-house pharmacies.

The highest coinsurance charged is 80%, which one plan applies, but only to brand-name drugs (with no coinsurance on generic drugs obtained through the plan's pharmacies). Another plan (of the same chain of HMOs) charges 70% coinsurance on all drugs, up to a maximum of \$50 per prescription.

As noted above, two plans charge a 20% coinsurance for Medicare-covered drugs, with a higher coinsurance (50%) applicable to non-Medicare-covered drugs. One plan charges 20% coinsurance only on Medicare-covered drugs (see comment below on immunosuppressives) with no coinsurance applicable to non-Medicare-covered drugs.

Five plans require coinsurance for immunosuppressive drugs while not requiring it for other drugs, and one plan specifies different levels of coinsurance for immunosuppressives based on inclusion in the plan formulary. One plan requires coinsurance only for a specific drug (Lupron and Lupron-Depot) and no other drugs.

Use of Formularies

The Medicare Compare data may not indicate all plans that use formularies. As noted above, 56 plans specify copayment differences based on formulary status of a drug, and twenty plans have differences in dollar limits (yearly caps) based on formulary status. Seven plans have formulary/non-formulary differences for both copayments and caps. Hence, at least 56 plans use formularies in determining the extent of drug coverage.

Over-the-Counter Drugs

- ▶ One plan offers coverage of over-the-counter drugs, limited to \$15 per month. Another plan includes vitamins and over-the-counter drugs prescribed by a physician as covered but counting towards the overall \$600 yearly limit for drug coverage.

Appendix: Methodology and Limitations of Study

We have attempted to provide the most conservative estimate of the maximum number of Medicare beneficiaries who have drug coverage. Therefore, we generally describe only the drug benefits of plans that include drug coverage for all enrollees in all basic packages, and we describe the features of the least generous level of drug coverage when multiple options are offered by a plan. The variation in packages is generally due to the use "flexible benefits," whereby plans can vary coverage in different counties of the same service area.

What is not known from this analysis, in addition to the extent to which beneficiaries obtain optional (supplemental) drug coverage through their risk plan, is the extent to which Medicare-eligible retirees enrolled in employer-sponsored Medicare risk plans are obtaining drug coverage that is not available to other Medicare enrollees in the plan. A recent analysis based on data from the Medicare Current Beneficiary Survey indicates that 95% of enrollees of risk plans have drug coverage, while this analysis indicates that nine percent of the total number of beneficiaries enrolled in risk plans are enrolled in a plan that offers no drug coverage of any kind. The difference in the two analyses is partly attributable to the number of beneficiaries who have drug coverage as employer-group-connected enrollees of Medicare risk plans. HCFA has no information on the extent of drug coverage offered to employer group retirees through Medicare risk HMOs.

The information included in the Medicare Compare data are assumed to be accurate. However, for 1998, HCFA had not standardized the language to be used in describing drug coverage. In some cases, plan representatives were called to obtain clarification of coverage. When the Medicare Compare information includes language such as "same as Medicare fee-for-service & prescription drug plan" or "same as Medicare coverage limitations plus \$1000 annual limit on prescription drugs," or "same as Medicare fee for service" and then specifies an annual limit, this is assumed to mean that the plan covers non-Medicare covered drugs and that the annual limit applies to such coverage (since plans would be prohibited from applying any caps on Medicare-covered drugs). This assumption is based on a conversation with a plan representative about how the plans were expected to complete information for Medicare Compare.

Although several plans were called for clarification of the description of coverage, there remain gaps in information regarding some of the plans (limited to a small number of enrollees). Not all subcategories include all plans. That is, if information is missing on certain aspects of plan coverage, the plan may be excluded from some subcategories but not from others. Wisconsin plans are only included in some of the analyses because of the anomalous nature of the drug coverage as compared to coverage in other plans. The State (until Medicare+Choice pre-emption takes effect) requires plans to offer drug coverage, consisting of coverage of 80% of actual charges after having met a deductible of \$6250 per year.

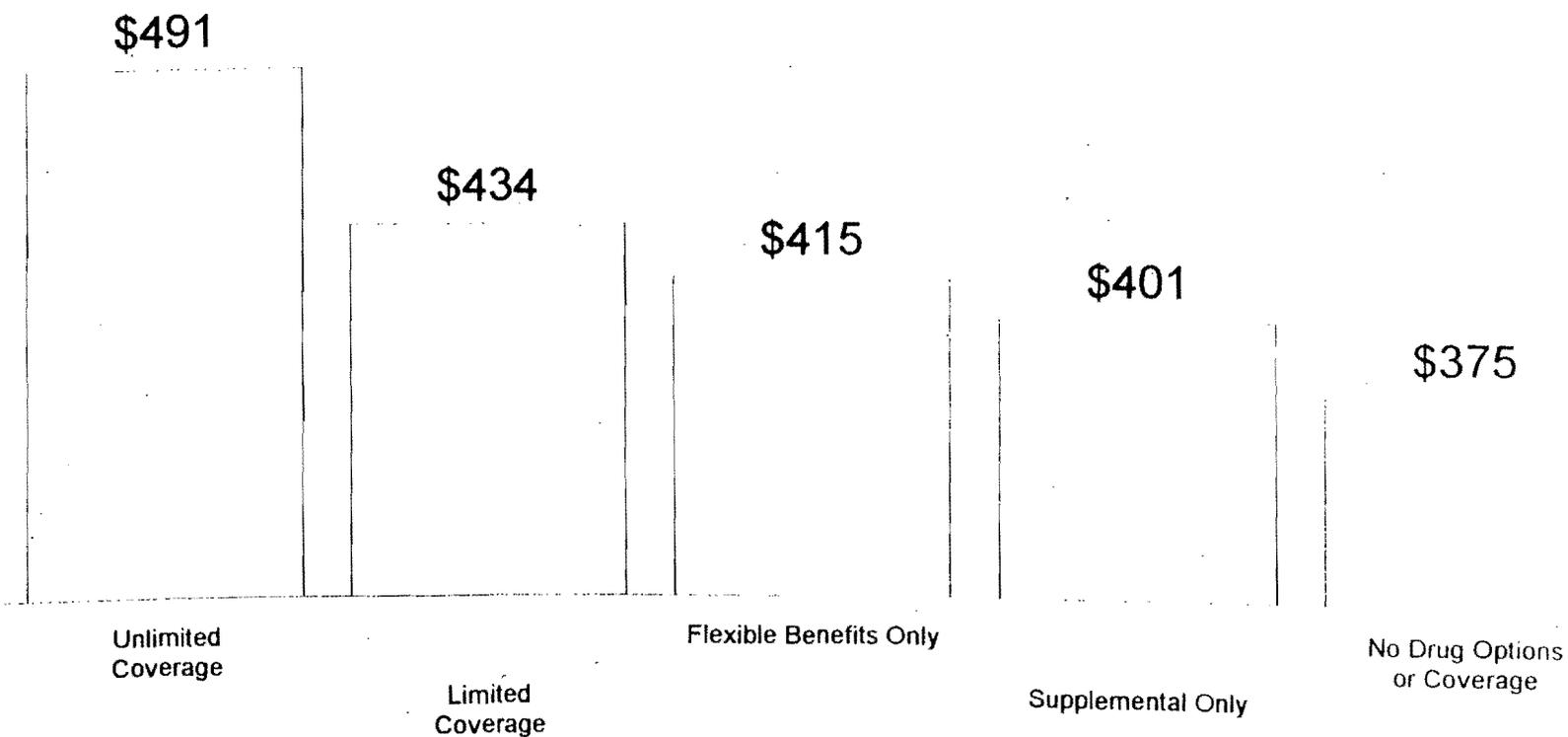
The following information should also be noted:

- ▶ Insignificant discounts (e.g., \$2 off generic; \$1 off brand), or coverage characterized as “discounts available,” are classified as “no coverage.”
- ▶ If quarterly or monthly limits apply, amounts are annualized to determine yearly limits (thus overstating coverage). At the same time, “carryovers” are ignored. That is, if the plan says that when an annual/quarterly/monthly limit has not been exhausted, it can be carried over to the following period, the analysis ignores this effect.
- ▶ When the Medicare Compare information refers to “preferred drugs,” the plan is categorized as applying a formulary.
- ▶ The term *plan* in this context refers to a contract area for a given organization, which encompasses a specific service area. One organization may have multiple Medicare plans in different areas of the country, or even in contiguous areas. Enrollment figures are for each separate plan of a given organization.

Distribution of Types of Drug Coverage by Number of Enrollees and Number of Plans

Type of Drug Coverage	Number of Enrollees	Percent of All Enrollees	Number of Plans	Percent of All Plans
Drugs in All Basic Plans	4,095,083	72.4%	214	67.9%
No Drugs or Flex/Option Only (Broken Out Below)	1,563,473	27.6%	101	32.1%
<i>Drugs as Flexible Benefit or "Compare" Listed Option</i>	730,716	12.9%	50	15.9%
<i>Drugs as Supplemental Only</i>	327,951	5.8%	14	4.4%
<i>No Drug Coverage at All Offered by Plan</i>	504,806	8.9%	37	11.7%

Average Monthly Medicare Capitation Payment Per Enrollee, by Extent of Drug Coverage Available in Plans, June, 1998



Distribution of Annual Limits Among Plans with Drug Coverage in All Basic Plans

Level of Annual Limit	Number of Plans	Percent of Plans	Number of Enrollees	Percent of Enrollees
TOTAL in Group*	209		4,062,530	
No Dollar Limit	35	17%	1,630,640	40%
Some Dollar Limit	174	83%	2,431,890	60%
> \$2000 to \$3600 (top limit)	6	3%	140,118	3%
> \$1000 to \$2000	50	24%	644,789	16%
= \$1000	48	23%	689,500	17%
> \$500 to < \$1000	31	15%	473,093	12%
\$500 or less	39	19%	484,390	12%

*Percentages are of total in group, which is all plans with coverage in all basic options except the four WI plans and one plan with dollar limit unspecified (5 plans, enrollment of 32,553).

Basis for Differences in Copayment Levels

	Number of Plans	Percent of All Plans With Coverage in All Basic Plans	Enrollees	Percent of All Enrollees in Plans with Coverage
Subset of Plans Using Copayments	177	83%	3,568,469	87%
No Differential Copayments	44	24.5%	1,112,558	30.3%
Differential Copayment Levels Based on:*	133	Percent of Subset	2,555,599	Percent of Subset
<i>Formulary/Non-Formulary</i>	24	18.0%	458,788	12.7%
<i>Generic/Non-Generic</i>	90	67.7%	1,956,478	53.9%
<i>Generic and Formulary</i>	16	12.0%	140,639	3.9%

Maximum Copayment Levels in Plans with Differential Copaymen

Maximum Copayment	Number of Plans	Percent of Plans	Enrollees	Percent of Enrolles
= \$30	5	3.8%	75,105	2.9%
= \$24 or \$25	29	21.8%	840,995	32.9%
= \$20	18	13.5%	227,426	8.9%
> \$10 and < \$20	50	37.6%	975,467	38.2%
= \$10	28	21.1%	421,167	16.5%
< \$10	3	2.3%	15,439	0.6%
Total	133		2,555,599	100

Excludes plans with coinsurance, deductibles, unstated limits.

Minimum Copayment Levels for Plans with Differential Copayments

Copayment Level	Number of Plans	Percent of Plans	Enrollees	Percent of Enrollees
Less than \$5	6	5%	64,805	2.8%
Five Dollars	61	46%	1,515,260	65.4%
Over \$5 and Less than \$10	40	30%	737,122	31.8%
Ten Dollars	26	20%	238,412	10.3%
TOTALS	133		2,317,187	

Excludes plans with unstated copayments, deductibles, coinsurance. Aside from the excluded plans, no plans have minimum copayment levels in excess of \$10.

MANDATORY

Jeffords-Kennedy Work Incentives Improvement Act. Allows people with disabilities to buy into Medicaid and Medicare and includes other pro-work initiatives.

Cost: OMB Passback: \$1.2 billion over 5 years (fully funded)

Issues / Status: No OMB, HHS or WH issues.

Medicare buy-in. Allows a limited number of people ages 62 to 65 and displaced workers ages 55 to 65 to buy into Medicare. Initiative also included COBRA extension / has no budget cost.

Cost: OMB Passback: \$0; WH Target: \$1.7 billion over 5 years

Issues / Status: Not supported by OMB or HHS since they believe that it uses scarce offsets and is not politically viable prior to the Medicare Commission's report. In last year's budget, POTUS expressed interest. Daschle and Gephardt want to re-introduce.

How much more

Medicare cancer clinical trials demonstration. Three-year demonstration to cover the patient care costs associated with certain clinical trials.

Cost: OMB Passback: \$0; WH Target: \$750 million over 3 years

Issues / Status: Not supported by OMB because of concerns about singling out a specific disease group and the belief that it substitutes for existing spending. In last year's budget. VP priority.

Medicaid disability option. Extends the current state option to cover nursing home residents with income/assets up to 300 percent of the SSI limit to people with long-term care needs who live in the community.

Cost: Not sure whether it's in OMB Passback: \$110 million over 5 years

Issues / Status: Recommended by HHS and supported by OMB staff. Important to the second prong of the disability agenda: reducing Medicaid's institutional bias. This is especially important since OMB rejected (and we concurred) on an HHS grant initiative to help states give people in nursing homes a community-based option.

Medicaid for foster care children. Allows states to continue Medicaid coverage for foster care children who turn 18 and lose Medicaid eligibility (extended through age 23).

Cost: OMB Passback: \$50 million over 5 years (fully funded)

Issues / Status: No OMB, HHS or WH issues. FLOTUS priority.

Medicaid and CHIP eligibility for legal immigrant children. Allows states to cover qualified immigrant children who enter the country after 8/22/96 in Medicaid and CHIP.

Cost: OMB Passback: \$200 million over 5 years (fully funded)

Issues / Status: No OMB, HHS or WH issues. Included in last year's budget. OMB priority.

CHIP funding for territories. Increase CHIP allotments to level proposed by the

Administration in 1997.

Cost: OMB Passback: \$144 million over 5 years (fully funded)

Issues / Status: No OMB, HHS or WH issues. Included in last year's budget, partly funded.

“Qualified Individuals” Medicare beneficiaries’ premium support reforms. Allows states to provide a higher level of premium assistance (50 percent of Medicare beneficiaries’ Part B premium, up from \$1.07 a month) for fewer people (up to 150 percent of poverty, rather than from 170 percent).

Cost: Not finalized, but hoping to make it budget neutral

Issues / Status: Supported by OMB, HHS and WH; needs to be budget neutral.

Children’s health outreach. Allows states to use up to 3 percent of its CHIP allotment for specific outreach activities.

Cost: Not finalized, but hoping to make it budget neutral

Issues / Status: Supported by OMB, HHS and WH. Although we hope it is budget neutral, we may have to fund it even if costs this since we are dropping last year’s \$900 million outreach initiative (presumptive eligibility in schools, child care centers, etc) and advocates will question our commitment to outreach.

OTHER

Long-term care tax credit. Give people with three or more limitations in activities of daily living (ADL) or their caregivers a tax credit of up to \$1,000 to help pay for formal or informal long-term care.

Cost: Treasury: About \$6.5 billion over 5 years (fully funded)

Issues / Status: Treasury is considering phasing this in. Could be a problem since close-hold conversation with aging groups suggest that at least \$1,000 is needed to make this credible.

Offering private long-term care insurance to Federal employees. Offers Federal employees the choice of buying private long-term care insurance policies. There would be no Federal contribution for this coverage.

Cost: OPM administrative costs (fully funded)

Issues / Status: No OMB, OPM, HHS or WH issues.

Tax credit for work-related impairment expenses for people with disabilities. Gives a tax credit of \$1,000 to people with disabilities (1+ ADLs who need personal assistance) who work, in recognition of their formal and informal costs associated with employment.

Cost: Treasury: About \$700 million over 5 years (fully funded)

Issues / Status: Important part of disability initiative.

Small business purchasing coalitions. Provides tax credits to employers who purchase health insurance for their employees through qualified small business purchasing coalitions. Only employers who did not previously offer coverage qualify for the credit of up to 10 percent of the employer contribution. Also, creates special, temporary tax provision for private foundations that want to fund the start-up costs of qualified small business coalitions.

Cost: Treasury: \$44 million (fully funded)

Issues / Status: Treasury remains skeptical about the benefits of this proposal. We would like to see a more aggressive initiative but have run into implementation problems when running it through the tax code. In last year's budget as a grant program. Republicans are likely to introduce a much more problematic version in 1999.

kill

HOSPITAL

20%

Kennedy : David N.

Prescription Drug Coverage Options

Program	Medicare Coverage	Federal-State Assistance Program	
		Federal Cost	Total Cost
Comprehensive Coverage under Medicare Part B	\$18 billion/year ¹	--	--
Catastrophic Coverage <i>\$1000 deductible & \$4000 limit on out-of-pocket spending</i> with Federal-State program for low- and moderate-income seniors	\$10 billion/year	\$2 billion/year	\$4 billion/year
Basic Coverage <i>\$1200/year with 20% cost-sharing</i> with Federal-State program for catastrophic coverage	\$8 billion/year	\$2 billion/year	\$4 billion/year
Low-Income Assistance Federal-State grant program	--	\$2 billion/year	\$4 billion/year

Tobacco Tax Revenues, Year 2000²

Increase in cents/pack	\$ in billions
75	9.1
59	7.4
50	6.5
25	3.4

¹Based on preliminary CBO estimates, adjusted to reflect discounts achieved by bulk purchases.

²Joint Tax Committee Preliminary Estimates, Nov. 24, 1998

Kennedy

Medicare: Prescription Drug Coverage

Proposal

The Administration should propose to raise the tobacco tax and earmark every penny of the increase to providing Medicare coverage for outpatient prescription drugs. Medicare coverage should be supplemented with a program of grants to states to provide further assistance to low and moderate income elderly, or those with catastrophic costs.

Background

Medicare's failure to cover drugs is a historical artifact and the most glaring example of the failure to modernize the program. In 1965, when Medicare was enacted, most private employer plans did not provide drug coverage--but virtually all do today.

Medicare's failure to keep up with changes in medicine and in private insurance practices has left beneficiaries vulnerable to catastrophic drug expenses and lack of access to critical therapies. Only one-half of senior citizens have any drug coverage at all and only one-third have reasonably comprehensive coverage, through an employer retirement plan or Medicaid.

Drug prices are projected to rise between 12 and 20 percent next year. Medicare beneficiaries fill an average of 18 prescriptions per year. Excluding premiums, prescription drugs account for one-third of Medicare beneficiaries' out-of-pocket costs. It is not uncommon for seniors citizens to face drug bills of \$100-200 per month or more. A 1993 study--before the most recent surge in drug costs-- reported that one in eight senior citizens said they were sometimes forced to choose between buying food and buying medicine. In addition, because most seniors do not have access to the savings provided by bulk purchasing, they pay inflated prices for the drugs they do buy--an average of twice as much as the prices paid by major bulk purchasers.

Most of the major medical advances over the next decades are likely to involve new and expensive drug therapies. Senior citizens deserve access to these cures.

The lack of Medicare drug benefits is a red-hot issue among the elderly and one of the greatest health problems facing our country. Addressing it would be a significant legacy for the Clinton Administration. It could be a key political part of a senior agenda to help us restore our party advantage among senior citizens. In the last election, Democrats gained only 44% of the votes from voters 60 or older, our weakest showing in any age group and one of the largest drop-offs between 1996 and 1998 among any of the standard demographic categories. If the Medicare Commission comes to any resolution, coverage of prescription drugs is likely to be part of the package. An Administration budget proposal would help identify the issue with the Democrats and also make Commission support more likely.

Possible Proposals

Medicare coverage could take a number of forms. The best, but most costly, would provide comprehensive coverage under Part B. A second option would be to provide catastrophic coverage only, supplemented by a Federal-State program to assist low and moderate-income seniors. A third option would be to provide basic coverage, e.g., a \$1,200 per year benefit under Part B, supplemented by Federal-State catastrophic assistance to those with exceptionally high costs. Fourteen states already have programs in operation to assist low and moderate income seniors with drug costs, although most are quite limited. A final possibility would be to propose only a program of Federal-State assistance for low-income individuals and, possibly, those with catastrophic costs. This approach would not have as broad public appeal as a new Medicare benefit, but would provide significant help to those who need it most.

Cost/financing

CBO has provided a preliminary estimate of a comprehensive Part B benefit. Adjusting their estimate to reflect more realistic available discounts produces a cost of \$18 billion a year. A catastrophic program providing a \$1,000 deductible and \$4,000 limit on out-of-pocket spending could cost \$10 billion. The basic coverage benefit, with 20% cost-sharing, would cost \$8 billion. The cost of each of these options could be reduced significantly by greater beneficiary cost-sharing or lower limits on what the benefit would cover. A reasonable target for a Federal grant program to provide assistance for low income seniors or those with catastrophic costs could cost \$4-\$6 billion, depending on whether it was a supplement to a Medicare benefit or a stand-alone and the generosity of the benefits provided.

Tobacco revenues are the most attractive source of financing for the Medicare part of new program. The cost to Medicare of tobacco-caused illness is at least \$10 billion, enough to cover the cost of a catastrophic or a basic program under Medicare. A \$4 billion Federal-State grant program could be financed with fraud and abuse savings and general revenues (\$2 billion) and State matching (\$2 billion).

The program options and associated tobacco tax levels are displayed in the attached table.

In addition to new revenues, there is an opportunity for very large savings through better management of prescription drug use and through avoiding unnecessary hospitalizations that result from lack of access to needed medications. Improper use of medications costs Medicare an estimated \$16 billion annually in hospital and physician costs.

**REPUBLICAN BLOCK GRANT FOR PRESCRIPTION DRUGS:
AN UNWORKABLE PRESCRIPTION FOR AMERICA'S SENIORS**

EXCLUDES 25 MILLION -- TWO-THIRDS -- OF MEDICARE BENEFICIARIES

- **About 25 million Medicare beneficiaries would get absolutely no help and have no option for basic prescription drug benefit under this plan.** Two-thirds of seniors and eligible people with disabilities have income above 175 percent (about \$14,600 for a single) or are eligible for Medicaid [MCBS 1996] and would not qualify for the plan's basic drug benefit.
- **Half of Medicare beneficiaries without any drug coverage today would receive no help from the Republican block grant plan.** The lack of prescription drug coverage among Medicare beneficiaries is not a low-income problem; 48 percent of those without drug coverage have incomes above 175 percent of poverty and would not qualify [MCBS 1996]. For example, an 85-year old with Alzheimer's disease and \$18,000 in income would be excluded.
- **Leaves out middle-income seniors who frequently need help as much – if not more – than low-income seniors.** High drug costs hit seniors of all incomes, not just the low income. A widow with \$15,000 in annual income and \$5,000 in annual out-of-pocket drug spending needs help more than an elderly couple with \$12,000 in income that has only \$1,000 in out-of-pocket drug spending – yet only that couple would qualify for help under the Republican plan.

ONLY A FRACTION OF LOW-INCOME SENIORS WOULD GET COVERAGE

- **Shifts responsibility for Medicare drug coverage to states – that do not want it.** Most of the nation's governors agree with seniors and people with disabilities: that gaps in Medicare coverage should be a Federal responsibility – not run by or financed by states. In fact, the National Governors' Association has explicitly rejected state-based drug plans: "If Congress decides to expand prescription drug coverage to seniors, it should not shift that responsibility or its costs to the states." [NGA resolution HR-39]
- **On average, less than half of Medicare beneficiaries eligible for state-based programs are enrolled.** Only 45 percent of poor Medicare beneficiaries who qualify for Medicaid drug coverage and cost sharing assistance programs actually enroll. Existing state Medicaid programs typically have complex applications that differ from state to state; long waits in welfare offices; extensive documentation requirements of income and assets; and poor education efforts [Kaiser Family Foundation, 1999]. Similarly, enrollment in the 15 non-Medicaid state pharmacy assistance programs has been very low, helping only 700,000 to 1.2 million seniors [AARP 1999; NGA 2000].
- **In contrast, 98 percent of eligible seniors participate in Medicare.** Seniors trust and rely on Medicare, and, as a result virtually all who are eligible join this voluntary program.

EMPTY PROMISE FOR THOSE WHO ACTUALLY ENROLL

- **Permits limits on types of drugs covered, the number of prescriptions that can be filled, and where the drugs can be purchased.** States could offer coverage consistent with their current

Medicaid or state drug assistance program benefits – some of which have strict limits. This means that seniors may only get coverage for certain diseases (Illinois, Maryland, North Carolina) or be allowed to fill only 3 prescriptions per month (e.g., Texas, Oklahoma, Wisconsin), forcing seniors to play Russian roulette with their medications. There is no guarantee that, when a doctor feels a particular drug is medically necessary, that the patient gets it. There is no assurance that seniors could continue to use their local pharmacies. And, unlike Medicare, what you get depends on where you live.

- **Enrollment would inevitably be capped.** The Republicans allows states to use Federal dollars to replace any current spending for prescription drugs above Medicaid coverage – which, nationwide, is about \$1.1 billion [NGA, 2000]. This inadequate and capped funding will result in waiting lists and uncertainty about whether eligible seniors and people with disabilities would get coverage at all.

STEP AWAY FROM – NOT TOWARDS – MEDICARE PRESCRIPTION DRUG BENEFIT

- **Would be quicker to cover all seniors through Medicare than low-income seniors through states.** It would take far longer to establish 50 separate state programs and enroll all eligible low-income seniors and people with disabilities than it would take to establish a nationwide Medicare option. States have to pass enabling legislation, determine the program design, set up systems for enrollment, hire new staff, and educate Medicare beneficiaries of the new option. In contrast, a Medicare benefit can use its existing systems, not require new or complicated applications, and integrate the benefit into current plan choices.
- **Step away from, not towards, Medicare benefit.** Diverting resources and energy towards a new, separate state-based program for prescription drug coverage will seriously delay the addition of a reliable, efficient, meaningful prescription drug benefit in Medicare. As one editorial said, “the step back from government that they proposed would create at least as many problems as it would solve.” [Washington Post, 9/7/00]
- **Rejection of Medicare approach is political, not practical.** The problem is not that it will take time to set up a Medicare benefit -- it is, for Republicans, Medicare itself. The same party that rejected the creation of Medicare in 1965 and advocated for a welfare program instead are taking the same approach today.
 - Ronald Reagan and Bob Dole opposed creating Medicare. As one historian wrote, Reagan “saw Medicare as the advance wave of socialism, which would ‘invade every area of freedom in this country.’” [As quoted in *New York Times*, 9/7/00] Newt Gingrich hoped that, by not improving Medicare and capping its funding, Medicare would “wither on the vine.”
 - And as recently as last year, Congressional Republicans supported a low-income benefit, not because it is quicker to implement, but it because they oppose a Medicare benefit: “It isn't a matter of whether there ought to be a prescription drug benefit offered by Medicare, but whether we're going to help those who need it most or launch a "universal" program we don't need and can't afford.” [Sen. Phil Gramm, *USAToday*, 6/30/99]

**THE ROTH / LOTT / BUSH DRUG PLAN:
AN UNWORKABLE PRESCRIPTION FOR AMERICA'S SENIORS**

LEAVES OUT TENS OF MILLIONS OF SENIORS AND PEOPLE WITH DISABILITIES

- **More than 20 million beneficiaries would get absolutely no help and have no choice for basic prescription drug benefit at least four years.** Over half (54 percent) of seniors and people with disabilities have income over 175 percent (about \$14,600 for a single) and would not be eligible for any assistance to purchase a basic drug benefit [MCBS 1996]. Most of these people have no or inadequate, unreliable or expensive drug coverage.
- **Nearly half of Medicare beneficiaries without any drug coverage today would receive no help from the Roth / Bush plan.** The lack of prescription drug coverage among Medicare beneficiaries is not a low-income problem. 48 percent of those without drug coverage have incomes above 175 percent of poverty and would not qualify [MCBS 1996]. For example, an 85-year old with Alzheimer's disease and \$18,000 in income would not be eligible.
- **Leaves out middle-income seniors who frequently need help as much – if not more – than low-income seniors.** High drug costs hit seniors of all incomes, not just the low income. A widow with \$15,000 in annual income and \$5,000 in annual out-of-pocket drug spending needs help more than an elderly couple with \$12,000 in income that has only \$1,000 in out-of-pocket drug spending – yet only that couple would qualify for help under the Bush plan.

LEAVES OUT MILLIONS OF LOW-INCOME SENIORS IT PURPORTS TO HELP

- **Shifts responsibility for Medicare drug coverage to states – that do not want it.** Most of the nation's governors agree with seniors and people with disabilities: that gaps in Medicare coverage should be a Federal responsibility – not run by or financed by states. In fact, the National Governors' Association has explicitly rejected state-based drug plans: "If Congress decides to expand prescription drug coverage to seniors, it should not shift that responsibility or its costs to the states." [NGA resolution HR-39]
- **State-based programs for seniors have failed to cover most eligible populations.** Only 45 percent of poor Medicare beneficiaries who qualify for Medicaid drug coverage and cost-sharing assistance programs actually enroll. Existing state Medicaid programs typically have complex applications that differ from state to state; long waits in welfare offices; extensive documentation requirements of income and assets; and poor education efforts [Kaiser Family Foundation, 1999]. Similarly, enrollment in the 15 non-Medicaid state pharmacy assistance programs has been very low, helping only 700,000 to 1.2 million seniors [AARP 1999; NGA 2000].
- **Allows states to ration coverage with severe limits on number and type of drugs covered.** States could use the Federal block-grant funding to extend their current Medicaid or state drug assistance program benefits – some of which strictly limit the number of prescriptions or types of drugs that are covered. This means that seniors would only get coverage for certain diseases (Illinois, Maryland, North Carolina) or be allowed to fill only 3 prescriptions per month (e.g., Texas, Oklahoma, Wisconsin), forcing seniors to play Russian roulette with their medications. And, unlike Medicare, what you get depends on where you live.

- **Virtually all of Roth's block grant dollars would buy out state programs – leaving little for beneficiaries.** The Roth plan claims to extend prescription drug coverage to 82 to 85 percent of Medicare beneficiaries at a cost that begins at \$1.3 billion in 2001. However, the plan allows states to use Federal dollars to replace any current spending for prescription drugs above Medicaid coverage – which, nationwide, is about \$1.1 billion [NGA, 2000]. This leaves only \$200 million for new coverage immediately. If the average cost per beneficiary were \$1,000 – typical in state programs – this would result in only 200,000 people receiving help – less than 2 percent of the 13 million Medicare beneficiaries who lack prescription drug coverage.
- **Would be quicker to cover all seniors through Medicare than low-income seniors through states.** It would take far longer to establish 50 separate state programs and enroll all eligible low-income seniors than it would take to establish a nationwide Medicare option. States have to pass enabling legislation, determine the program design, set up systems for enrollment, hire new staff to handle enrollment, and educate Medicare beneficiaries of the new option. In contrast, a Medicare benefit can use its existing systems, not require new or complicated applications, and integrate the benefit into current plan choices.

REPUBLICANS REJECTION OF STRENGTHENING MEDICARE IS PAR FOR COURSE

- **Rejection of Medicare approach is political, not practical.** The problem is not that it will take time to set up a Medicare benefit -- it is, for Republicans, Medicare itself. The same party that rejected the creation of Medicare in 1965 and advocated for a welfare program instead are taking the same approach today.
 - ◆ Ronald Reagan and Bob Dole opposed creating Medicare. As one historian wrote, Reagan “saw Medicare as the advance wave of socialism, which would ‘invade every area of freedom in this country.’” [As quoted in *New York Times*, 9/7/00]
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Issues Surrounding Adding Prescription Drugs to Medicare

AARP is committed to creating an affordable Medicare prescription drug benefit that would be available to all beneficiaries, so that they may benefit from longer, healthier lives, fewer invasive medical procedures, and reduced health care costs. We appreciate the Committee's interest in this issue and look forward to working with the Congress and the Administration to assure that a prescription drug benefit that is available and affordable to all Medicare beneficiaries becomes part of Medicare's defined benefit package. To that end, we have identified what we believe are the fundamentals of a Medicare prescription drug benefit:

- A Medicare prescription drug benefit must be *available* to *all* Medicare beneficiaries. First, the benefit should be *voluntary* so that beneficiaries are able to keep the coverage that they currently have, if they choose to do so. A Medicare prescription drug benefit should not be an incentive for employers to drop or cut back on retiree health coverage. Second, the benefit needs to be *affordable* to assure enough participation and thereby avoid the dangers of risk selection. To this end, the government contribution will need to be sufficient to provide a premium that is affordable, and a benefit design that is attractive to beneficiaries. In other words, this is not simply a matter of beneficiary affordability, but equally important, the fiscal viability of the risk pool. Medicare Part B is a model in this regard. The Part B benefit is voluntary on its face, but Medicare's contribution toward the cost of the benefit elicits virtually universal participation.
- Prescription drugs should be part of a defined benefit package. It is critical that beneficiaries understand what is included in their benefit and that they have dependable and stable prescription drug coverage.
- The benefit must assure beneficiaries have access to medically appropriate and needed drug therapies.

- The benefit must include quality improvement components to reduce medical errors and mismedication and to help reduce overall health care costs.
- The benefit must include meaningful cost-containment mechanisms for both beneficiaries and Medicare. This should include drug-purchasing strategies that enable Medicare beneficiaries and the program to take advantage of the aggregate purchasing power of large numbers of beneficiaries.
- The benefit must provide additional subsidies for low-income beneficiaries to protect them from unaffordable costs and assure that they have access to the benefit.
- The benefit must be financed in a fiscally responsible manner that is both adequate and stable. AARP believes that an appropriate amount of the Federal budget surplus should be used to help finance a prescription drug benefit.
- A new prescription drug benefit should be part of a strong and more effective Medicare program. Prescription drug coverage must be integrated into the program in a manner that strengthens Medicare. Prescription drug coverage must also improve Medicare's ability to support modern disease management and prevention strategies. Many of these strategies hold promise to both increase health outcomes and lower program costs.

Key Principles That Should Guide Broader Medicare Reform

As this Committee also examines the broader issue of reforming Medicare, AARP urges you to consider the fundamental principles that, since Medicare's inception, have helped to shape it into such a successful program. We believe strongly that these principles must be the basis of any viable reform option.