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Briefing: Medicare Basics, From (Part) A to D
May 16, 2005

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ED HOWARD: I want to welcome you to this program on the basics of Medicare. I'm Ed Howard of the Alliance for Health Reform on behalf of Senator Rockefeller, our Chairman, and Senator Frist, our Vice Chairman and the rest of the board. Thanks for joining us. Medicare, of course, is the federal health insurance program for elderly and persons with disabilities. I also want to welcome not just the folks here in the room in the Dirkson Senate Office Building, but the Congressional Staff in state and district offices, and a few reporters as well, who are listening or watching around the country. Our partner in today's program is the Kaiser Family Foundation. We're very pleased to have Trisha Neumann, Vice President of the Foundation here with us. We'll hear from her in just a moment.

Now, for Americans who are most in need of healthcare, that is people over 65 and those with severe disabilities, Medicare is the major factor in their ability to get the care that they need. It's been in place for 40 years. It's among the most popular government programs in existence. It's also one of the biggest and most expensive, soon to get a lot bigger and a lot more expensive, so there are a whole lot of reasons why we should put ourselves through this refresher course in Medicare. Now, the goal of today's program I should say is not to debate the very real and numerous policy issues on Medicare.

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There are a whole lot, but rather to help give us all a better grasp of how the program works now, and how it's expected to work over the next few months. We sometimes call these primer programs the ABCs of Medicare, if you will, but now that we've added a Part D to Medicare, we altered the title of the session to reflect that. Now, a few logistical items before we get to our program. In your packets, those of you here in the room, you'll find a lot of background information, including speaker bios that will give you more than I'll have time to give you about the speakers. If we have the presentations, you have them in your packets or pick them up there, and those of you who are listening around the country and watching, some of those presentations were not available at the time we sent the materials to you. You can find all of those materials or at least will find them by mid-afternoon today on our website, that is, allhealth.org, and kaisernetwork.org, where you can also see a rebroadcast of the webcast of this briefing beginning at the close of business today.

As you might have inferred, some of you are watching live by webcast at kaisernetworks.org. Some of you are listening to a conference call. If you are on one and want to do the other, go to the Alliance website at allhealth.org and it will tell you how to get either the conference call if you're watching the webcast, or vice versa. If you have questions at the appropriate time, and that is the whole point

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of this session, you can call the Alliance at 202-789-2300 or e-mail us at frontdesk, all one word, at allhealth.org, and we'll get the questions to our speakers, or at least get as many of them as we can in the time we have. And in a few days you're going to be able to get a transcript of this briefing on both the kaisernetworks.org website and the Alliance website. So, at the appropriate time, those of you in the room can come to the microphones, or fill out a green question card and those of you who are in state and district offices, you know how to get a question to us, and there is also an online evaluation form for you that you can fill out very easily. So, enough of the procedural stuff.

As I noted, we have with us today Trish Neumann, of the Kaiser Family Foundation, who is not only a Vice President at the Foundation, and head of its Medicare Policy Project, but also one of the most prominent experts around on Medicare. She's a veteran of both the House and Senate Committee staffs. She holds a degree of Doctor of Science from Johns Hopkins, and we are very pleased to have her back with us today. Trisha?

TRICIA NEUMANN, Sc.D.: Thank you. I'm gonna be using overheads and I think you have the handouts. I'm going to be doing a very quick overview of the ABCs and D of Medicare and very fast speed. So, just to begin, as Ed was saying, this is Medicare's 40th anniversary. Medicare was enacted in 1965. At the time, about half of all elderly people did not have

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hospital insurance. It is Title 18 of the Social Security Act and it was enacted with a companion program, which is Title 19. That's Medicaid, which is Title 19 of the Social Security Act. Today there are almost 42 million people who are getting health insurance coverage under the Medicare program. We think of it as a program for seniors, but it provides important health insurance coverage for more than six million people who are under 65 with permanent disabilities. We'll talk about the ABCs. We'll also talk about the new Part D, which is the drug benefit, in a minute. The majority of Medicare beneficiaries today are in the traditional fee-for-service program, but a little bit more than ten percent are in managed care or Medicare Advantage plans, something that Linda will talk about a little bit more in a few minutes.

Medicare is estimated to be roughly 13 percent of the federal budget. It is a major part of the healthcare system. Medicare pays for about 17 percent of total national health expenditures, but for certain services it plays an even larger role. Medicare pays the bill for about 30 percent of all hospital services and 20 percent of all physician services. As you know, today Medicare doesn't pay for much prescription drugs, but that will change in the very near future.

Before talking about the program, I just want to talk very briefly about the people who rely on Medicare for their health insurance coverage. Roughly four in ten people on

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Medicare have incomes below about 150 percent of poverty. For an individual, that's a little bit more than $14,000, so many live with modest in comes. Twenty-nine percent are in fair or poor health, 23 percent or about a quarter have cognitive impairments and I want you all to keep that in mind, because the fact that so many people on Medicare do live with cognitive impairments, it is important for thinking about ways to make the program work for those, no matter what their health or cognitive situation may be. It's also important to remember that nearly 18 percent, or nearly seven million people are dually eligible for Medicare and Medicaid, so changes to both programs play a major role for these people who have low incomes and significant healthcare needs.

The population is diverse, and therefore the spending on Medicare sort of reflects the diversity of the healthcare needs. As you can see in this exhibit, spending on Medicare is highly skewed. By that I mean, a very small share of the Medicare population, ten percent, account for more than two-thirds of all healthcare spending. That's important for a couple of reasons. It's important because when people think about strategies to control the growth in Medicare spending or to control expenditures, it's hard to do that without affecting people who have the highest healthcare spending, and that's a relatively small group of people. It's also important as Medicare moves to pay for more care in a capitated basis, when

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you pay a fixed amount per person, it's important to adjust those payments so that plans don't have a disincentive to serve the very small share that do have such extremely high healthcare spending.

Next slide shows you average per capita spending in 2002. It's interesting here to note first, average per capita spending is a little bit more than $5000 that year, but what is also interesting is that slightly higher were the elderly than the non-elderly disabled, which some see as pretty counter-intuitive, and there is a very small group of people, those with end-stage renal disease, for whom Medicare per capita spending is close to $40,000.

Okay, let's get to the ABCs. What is part A? Part A is generally inpatient care. It's the hospital insurance part of the program. It pays for inpatient hospital care, skilled nursing facility care, which is limited, some hospice care, and limited home health services. Part A services are subject to cost sharing. There's a deductible of a little bit more than $900 per episode. There is cost sharing for long inpatient stays. There's cost sharing for the skilled nursing facility stays beyond 20 days. There is no home Healthco payment, which makes it different from the other benefits. Generally, people do not pay a premium for Part A services unless they haven't worked the full 40 quarters, which is about ten years. Part A is funded primarily by the payroll tax. You and I all pay

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that. You see it on your pay stub. It's 1.45 percent. That's paid by the individual and their employer. It goes into the Part A Trust Fund, which you hear about a lot, the Hospital Insurance Trust Fund. So individuals are entitled to Part A if they or their spouse have been contributing their payroll taxes for 40 quarters or ten years.

Part B. I apologize for going quickly, but I need to. Part B is the supplementary Medical Insurance program. It helps pay primarily for outpatient services, physician services, outpatient hospital care, X-rays, dental, preventive services, some of the new ones that have just come along, like the Welcome to Medicare physical, some home health, some mental health services. It also is subject to deductibles and coinsurance. Part B is funded differently from Part A. There are premiums that cover roughly 25 percent of the total and the rest is out of general revenues. Significantly, there will be a change to the financing of Part B with the new income-related premium that will begin in 2007.

What is Part C? Part C is now called the Medicare Advantage part of the program. It refers to Medicare HMOs, PPOs and a range of private plans that generally receive a capitated payment from Medicare to provide services. Medicare Part C isn't separately financed, so it differs from A and B because these plans provide both A and B services. As Linda's going to talk about more in detail, the program enrollment has

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waxed and waned over time. It's now a little bit more than ten percent.

When you put it all together and you look at spending, you see that Part A services account for roughly 45 percent of the total. Part B is about a third of the total, and the Part A and B services, including the managed care plans and some home health, account for about 20 percent of the total.

That tells you what Medicare does cover. I want to say a little bit about what Medicare does not cover. There are gaps in the Medicare benefit package. As you all know, there's no outpatient drug benefit until 2006. There's very limited long-term care, which is obviously a critical issue for this population. No hearing aids, no eyeglasses, no dental care. And there are high cost sharing requirements. All told, Medicare pays less than half of total health and long-term expenses for the people on Medicare so most people have some form of supplemental insurance, and at least seniors pay a little bit more than 20 percent of their income for their healthcare expenses. Looking at supplemental insurance today, employer coverage is the primary source of supplemental coverage, covering a little bit more than a third of all people on Medicare through retiree health benefits. That's followed by individually purchased Medigap policies, Medicare HMOs, and Medicaid plays a very important part in supplementing Medicare for those with low incomes, assisting close to seven million

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people with prescription drugs, long-term care and Medicare cost sharing.

Now that we've quickly done the ABCs, I would be remiss in not talking a little bit about the D, which is the new and exciting part of Medicare. Part D is the new outpatient prescription drug benefit that will be administered through private plans. People in traditional Medicare can get this Part D benefit from a stand-alone drug only plan, or from an integrated Medicare Advantage plan. These plans will provide standard prescription drug coverage, which is defined in the law, but they have flexibility to modify the benefit package and the drugs that are covered, subject to certain constraints. One of the greatest features, I think, of the Part D drug benefit are the significant financial assistance protections for those with low incomes. Again, there's too much to go into that right now, but those are just the highlights.

The other important part to know about Part D is it makes a major change for those who are not in Medicaid, who will now get their prescription drugs no longer paid for my Medicaid, but by Medicare Part D plans. This is what the standard benefit looks like. This is what was defined in the law. The Part D benefit will have its own premium, estimated to be $37 a month. There is a deductible. There's a copay. There's what's famously called the donut hole, which is that gap in the middle at $2850 and the Medicare pays 95 percent of

expenses above that threshold. But the important point to remember is this is the standard and plans will vary, and so seniors and people with disabilities will have to look at their options and assess which plan is most likely to meet their needs.

This next slide looks at the decisions for a Medicare beneficiary, and very, very briefly, I just want to kind of walk you through it. Here's what a typical person n Medicare should ask themselves this fall. The first on is to D or not to D, to sign up for Part D or not, and that's an important question. If they do not sign up for Part D, they might stay in an employer plan. They might stay with their Medigap, although they would maybe be subject to penalties for late enrollment if they do. They might decide to go without prescription drug coverage. It is a voluntary program, but there are penalties for delayed enrollment, so those are options that think through very carefully. On the right side is the enrollment in Part D. If you enroll in Part D in a plan, you can stay in traditional Medicare and sign up for a drug-only plan, or go into a Medicare Advantage plan to get all your Medicare benefits or your new Part D benefits. There are many decisions to be made. People need to think about premiums, cost sharing, and whether the drugs they take are covered by the plans that are available in their area. One of the things that we have seen, at least according to press accounts, there

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seems to be a significant number of plans who have expressed their interest in the program, so there may well be a lot of choices for seniors.

Future challenges: I think Bill's gonna talk a little bit about financing challenges. I'm just gonna say that they major challenge here is the growing number of Medicare beneficiaries who will be on the program and the declining number of workers available to support retirees, creating a real challenge in finding ways to maintain programs for a growing aging population. So finally, there are a number of challenges facing the program. I think the biggest one Linda will agree to is implementing the Part D drug benefit, which will take a lot of work in the very near future. Clearly, strengthening protections for the low-income and chronically ill population is very important. Setting fair payments, a topic that Bill will be talking about is clearly an ongoing concern. And securing Medicare financing for future generations, since the program has been so popular and successful currently. That will be a challenge as the years go on. Thank you.

ED HOWARD: Thank you, Tricia. Almost as big a challenge as getting over all of that material in ten minutes. Very good job. Now we're gonna hear from Linda Fishman, who was recently named the Director of the Office of Legislation for the agency that runs Medicare, the Centers for Medicare and

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Medicaid Services. Linda's also served on both the House and Senate committees that oversee Medicare. She's helped to shape key Medicare legislation that's detailed in her biographical sketch, including the Medicare Modernization Act that set out the Part D benefit, among other things. She's also been a senior advisor for the CMS Administrator. She's graced several Alliance programs in the past, I'm pleased to say, and we're very happy to have her back. Linda?

LINDA FISHMAN: Thank you, Ed. A couple points of my own housekeeping: For those who are connected to us, another mechanism, and that is in the room, you don't have my slides. They will be available shortly as Ed said, and I'm going to try, because this is a Medicare basics program, to not rely too heavily on alphabet soup acronyms and try to adhere to the actual names of things, but just so you know, MMA, for those of you who aren't familiar with it, stands for the Medicare Modernization Act that was passed in 2003, and that's what we're all about today at CMS. So with that, left click. Okay. I'm learning how to use this. Okay. Well, now I'm at my place, but we have that little menu. I'm gonna keep going in the interests of time.

We have to keep going. There are several types of private plans offered through the Medicare program. Medicare Advantage, as Trish just said, is comprised of coordinated care plans, or CCPs, and since the enactment of the MMA, these are

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also known as local Medicare Advantage plans. They're organized around counties. Those are the service areas for these plans. There are also types of plans—well, HMOs are coordinated care plan preferred provider organizations, or PPOs, provider sponsored organizations, PSOs. There aren't very many of those in the Medicare program. There are still some cost-based plans, private fee-for-service plans and medical savings accounts, or MSAs. An MSA is a combination of a high-deductible insurance policy and a tax advantage personal savings account for medical expenses. I'm not really going to address those today. We're going to focus mostly on the coordinated care plans. MMA provided even more private choices to beneficiaries, and that's what CMS is engaged in the implementation of, Regional PPOs, which importantly are not going to be county-based, and something called SNIPS. That's how we refer to them at CMS. Those are called Special Needs Plans, and those are plans for beneficiaries with certain health conditions. SNIPs limit their enrollment to special needs beneficiaries, or serve a disproportionate percentage of special needs beneficiaries, which ensures that the needs of these populations are met as effectively as possible. Two groups of special-needs Medicare individuals are specified in the MMA. These are beneficiaries who are institutionalized, and those who also have Medicaid coverage, also called dual-eligibles. CMS can also establish requirements for other

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special needs groups, namely those with severe or disabling chronic conditions that would benefit in enrollment in a special needs plan.

Let’s see if I can do this right. Ah, a little bit of history, first of all. I want to make the point very emphatically that private plans are not new to the Medicare program. In fact, their history goes back to 1971, when the HMO Act allowed the development of cost-based plans. Just to give some of you younger folks in the audience an appreciation of that, the Healthcare Financing Administration, or HCFA, which preceded CMS, wasn’t even established until 1977, so that gives you a flavor of how old they are. In 1982, there was legislation called TEFRA that facilitated risk contracting with the government between HMOs and the Healthcare Financing Administration.

In 1997, probably, you know, where we’re a lot more familiar with legislative action, Congress passed famously the Balanced Budget Act of 1997, or the BBA, and in that legislation, the risk contract program was replaced with something called the Medicare Plus Choice program, or M-Plus C program. The BBA established a new payment structure for private plans that had two goals. One was to reduce the spending of the Medicare program and the other was to reduce the variation in payments across the country, because as I pointed out, it was a county-based payment system, and those of

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you who work in the Congress and are familiar with health policy know that variation across the country in terms of provider payments and actually what beneficiaries may receive through private plans continues to be an important issue and one that the Congress debates on an annual basis.

In 1999 and 2000 there was legislation enacted to increase payments to M-Plus C plans and to make it easier for plans to contract with Medicare by reducing administrative and regulatory burden. Well, in 2003, in December, President Bush signed the Medicare Modernization Act, and created a new program called Medicare Advantage. The MMA most importantly added a prescription drug benefit. It is a voluntary benefit to the Medicare program, and I would point out that the Part D benefit, independent of whether you sign up for a Medicare Advantage plan will be delivered by private plans, so that's another aspect in which private plans are taking on new importance in Medicare.

The MMA also brought more choices and new choices to the program. Regional PPOs, which I'm going to talk about in a little bit more detail in a minute. As Trish pointed out, the history of Medicare private plans in terms of enrollment and participation has waxed and waned over the years, as she said. I say it's been a bit bumpy, especially in the 1990s. Peak enrollment was 6.4 million beneficiaries in coordinated plans in 1999. Today in 2005 there are about 4.9 million

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beneficiaries enrolled in 188 coordinated care plan contracts. There were declines in plan participation and enrollment from 2000 to 2004. Remember, as I said, the BBA was designed to actually reduce Medicare spending, and Medicare Plus Choice plans were also affected by that, but now the trend appears to be up in 2005. By the end of this year, CMS predicts that more than 90 percent of beneficiaries will have access to a Medicare Advantage plan and that by the end of the year, private plans will be available in 47 states. Now, I know most of you in the audience want to know, well, what's going to happen in 2006, and right now, the best I can say is that the response to CMS in terms of private plans offering products is what we like to say, we call it robust, and in March, CMS received letters of intent to bid from plans, and the response was very good, and we're very pleased about that. I'd also point out that in 2006 and 2007, there will be no new local MA plans. Those are the county-based ones on the local level, not regional, and there won't be any local PPOs allowed into the program.

What do Medicare Advantage plans offer people? First of all, they provide the full package of Medicare Part A and Part B benefits to their enrollees. They attract beneficiaries who want a good deal, and by that I mean, lower premiums, lower cost sharing, more benefits, and that's why they join Medicare Advantage plans. Plans may offer additional benefits to beneficiaries. They can charge additional premiums for those

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benefits, or they may offer additional benefits, lower the premiums, or they can contribute to a rainy day reserve fund, but hardly any plans do. They all put all that money back into offering extra benefits.

The goals of the MMA, and I think the goals of CMS at the present time are three: First of all, we're trying to maximize plan choices, but especially in rural areas. Rural areas have always felt shortchanged by the absence of these plans, and we're hopeful that regional PPOs will deliver those kinds of services to beneficiaries in rural areas. We are interested in offering better benefits for lower costs, and we are interested in introducing more competition into Medicare Managed Care.

How are private plans paid? Well, CMS makes a monthly prospective payment for each plan enrollee in a payment area, which I said earlier, is county-based. Prior to 1997, the per capita rate was based on 95 percent of the costs Medicare would have incurred if the same beneficiary had stayed in the original Medicare program. But in 1997, the BBA broke the direct link to the county level fee-for-service spending and created three payment prongs. I know this is going to get a little technical, but it's important that we talk about it. They were payment floors, or minimum payments. There was a minimum guaranteed increase of two percent, or what's called a blend of national and local rates. Remember I said one of the

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goals of the BBA was to reduce the variation in payment rates at the county level on a national basis. Payments to plans are also adjusted for the health status of the enrollee. This is called risk adjustment. The risk adjustment mechanism is designed to adjust the capitation rates to reflect expected healthcare spending differences among plans based on the characteristics of enrollees. The early form of risk adjustment was called demographic, and it was based on administrative data, enrollees' age, gender and other features, such as whether beneficiaries are enrolled in Medicaid. The system was intended to pay plans to enroll sicker people more money while paying those who enrolled healthier people less money. In 1997, Congress directed the Secretary to improve the risk adjustment system. The improved system is now based on hierarchical health condition categories and on demographic features. It is being phased in gradually over time to allow plans to adjust to changes in their payments.

What changes did the Medicare Modernization Act make? Now, this is the really important stuff that CMS is working on now. As I said, the most notable accomplishment was to add a prescription drug benefit to the Medicare program, beginning in 2006. Another important feature is the introduction of the regional PPOs. These types of plans are popular in the private insurance market. Many of you probably participate in a PPO, but they are new to the program on a regional basis, and they

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were included to stimulate the number of options available to beneficiaries in rural areas. MMA also changed the payment structure immediately for plans in March 2004, which had the effect of increasing payments to plans. In March 2004, a fourth payment prong—remember, there were three before—was added to the structure to calculate MA payments. In 2004, plans are paid the highest of the floor, a minimum percentage increase, a blended rate or a new amount, which is 100 percent of the fee-for-service payments made for persons in original Medicare. Additional changes will be made to the payment structure in 2006. The current process will be replace by a competitive bidding process. The Secretary will determine MA local rates by comparing plan bids, which is the plan's estimated average of the revenue it requires to what's called a benchmark, or the maximum amount that the government is willing to pay. The benchmark will be based on the previous year's payment in a local area, updated by an increase mandated by statute. While this process is called competitive, the benchmark is not really determined in a competitive manner. Plans will compete with each other to attract beneficiaries and enroll them, but payments will be made based on the increases defined in statute. After plans submit their bids, the Secretary will have the authority to negotiate the bid amount, similar to how the Director of the Office of Personnel Management, or OPM negotiates on behalf of federal employees,

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or the federal employees' health benefit program. If the plan's bid is less than the benchmark, its payment will be its bid, plus a rebate of 75 percent of the difference between the benchmark and the bid. Plans can use their share of the rebate to provide additional benefits, reduce cost sharing or apply the amount to the Part B premium or the drug premium. The remaining 25 percent is to be retained by the federal government. If the plan's bid is more than the benchmark, its payment will be the benchmark amount, and each enrollee in that plan will have to pay an additional amount that is equal to the amount by which the bid exceeds the benchmark. Now, key dates to remember that are coming up shortly are that on June 6th, that's the deadline on which plans must submit bids. That's our bid date. By September, CMS will have approved and signed contracts with plans that will participate in 2006, and then beginning November 15th, and running through May 15th of 2006, there will be an annual coordinated enrollment election period. In subsequent years it's going to be from November 15th through December 31st, but we're giving people extra time to decide whether to, as Trish says, to D or not to D, or join an MA plan.

Finally, the last important element of the MMA creates a six-year program in 2010 called the comparative cost adjustment program. It will occur in a fixed number of geographic locations, and it's designed to enhance competition

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among local MA plans and to enhance competition between MA plans and the original Medicare fee-for-service program. The important point here is that the Part B premium for persons enrolled in traditional Medicare may actually be adjusted up or down within certain limits, depending on the relative costs of original Medicare to the managed care plans in that area.

Okay. MA regional plans, and I have a map that I'll show you in a minute. Regional plans will be new choices for beneficiaries. In December '04, CMS announced the creation of 26 PPO regions, and that's what it looks like on the US map. A PPO must serve the entire region, so for example, the light green states, you can see Montana, Wyoming, Nebraska, the Dakotas, Minnesota and Iowa are all going to be in the same region, so the regional PPOs will be submitting a big to service that entire geographic region. On the other hand, you can see that there are some regions that are a state. For example, Florida is its own region. Arizona is its own region. It looks like Ohio is its own region. The idea was, as I said, to get plans to serve those states where they were not previously. Regional plans are going to—I hit the wrong one—I want to go backwards. If you could take me back to that slide, please, regional plans will cover both in and out of network services. They must offer a limit on out-of-pocket expenses, and they have to offer a unified Part A and B deductible if they have a deductible. Regional plans bid based on a

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benchmark, and it has two elements, and this is different from the MA local plans. Part is determined in the statute, but another part is based on the weighted average of plan bids. This introduces an entirely new form of competition to Medicare between plans by basing part of the benchmark on bids submitted by the plans, and that's different than the MA local plans.

Similar to local plans, regional PPOs also get rebates when they bid below the benchmark. And enrollees similarly will have to pick up the difference if the bid ids above the benchmark and they want to be in that plan. There are financial incentives in the MMA for regional PPOs to form. First of all, starting in 2007 there is a $10 billion stabilization fund. It was created to encourage plans to enter markets and also to retain them in the MA program. Second, during 2006 and 2007, Medicare will share risks with MA regional plans if its costs fall above or below statutorily specified risk corridors. And third, there will be $25 million available starting in '06 with an increase each year for additional payments to certain hospitals that demonstrate they have high costs that would prevent them from joining a Medicare Advantage network. That's the map again.

I want to just say a brief word about private fee-for-service plans. These private plans don't have a lot of enrollees, only about 26,000 people. They are basically like an indemnity-type insurance plan. They are not administered by

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the government and they allow unrestricted access to providers. Providers are paid on a fee-for-service basis.

Finally, Medigap, supplemental insurance. Also administered by private plan, this is individually covered purchase coverage for services not covered by AB. For the deductibles and for coinsurance Trish showed earlier that vision, dental, hearing services are not covered by the Medicare program, and seniors often buy Medigap plans to cover those costs. There are ten standardized plans. They are sold by private insurance companies. All the Medigap plans cover Part A and Part B coinsurance. About 28 percent of beneficiaries had Medigap insurance in 2001. I think Trish's slide in 2002 showed 22 percent, I want to say.
There are three Medigap plans. This was in the MMA. Three Medigap plans offer outpatient drug coverage, and they're called HIJ, for those of you not familiar with Medigap. They are not going to be available starting in January 2006 to new subscribers because the idea was that we were going to put a Medicare drug benefit into place that's actually a much better deal than the cost of buying an HIJ plan, which are very expensive. The last data I saw shows a J plan costs at least $200 a month, and that was back in 2001, something like that, so this will be much better. And then finally, two new Medigap policies were created in the MMA. They're going to be called K and L, and they will be available in 2006. They're going to

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offer catastrophic costs for those in the original Medicare program, because remember there's no out-of-pocket limit in traditional Medicare. They will have other aspects as well, probably, but that's one of the things they're required to do, and with that, I will stop.

ED HOWARD: Thanks very much, Linda. Our final presentation—Oh by the way, if any of you still has your cell phone on, please turn it off as a courtesy to allow the rest of us to concentrate here. The final presentation is from Bill Scanlon, who's been helping people like me understand Medicare for more years than I want to admit. He's now a Senior Advisor at Health Policy R & D, was recently named to the Medicare Payment Advisory Commission. Many of you know Bill from his decade-plus tenure as the Senior Health Official at what was then the General Accounting Office. I haven't quite internalized that new name yet. He's also, I'm pleased to say, a veteran of some Alliance programs, and he's here to help us understand better some of the payment issues involved.

WILLIAM SCANLON, Ph.D.: Thank you very much Ed. It's always a pleasure to be part of an Alliance event. I found this one to be particularly interesting for myself, since I teach a course in health policy and spend about eight weeks on Medicare and so the idea of doing payment policy and financing in about ten minutes, I'm curious as to what I'm gonna say and

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maybe it'll be beneficial to my future students, though. So let me—These might be from a January Alliance event.

ED HOWARD: But they're very attractive!

WILLIAM SCANLON, Ph.D.: They're very attractive, right. Do we have the others?

ED HOWARD: You should have, by the way, the hard copy of Bill's slides, and then you can go from there.

WILLIAM SCANLON, Ph.D.: Okay. In the interest of time, let me go ahead. What I wanted to start off was talking about some Medicare financing, and Trish has given you some of that in the sense that Part B and Part A are financed very differently. Part A we pay for through payroll taxes while we work. Part B is a combination of general revenues and beneficiary premiums after we become Medicare eligible. The important things I think about the Part B premium are the fact that it's such an important incredible deal in that it only costs 25 percent of the overall Part B program costs, so you're being heavily subsidized, and it's a national premium. It was about $78 a month this year. It's projected to rise to $89 a month next year. Trisha noted that there's going to be a big change coming in 2007 in that for the first time it will be income-related for people making more of an Adjusted Gross Income of more than $80,000. They will be paying a bigger share of the Part B costs.

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Part D is going to be different than Parts A and B in that Part D is going to have three primary sources of revenue, from the federal government and the state governments and then the third source being beneficiary premiums. As you can see, now we're on the right slides. The federal revenues are going to contribute about 78 percent, state revenues about 11 percent, and beneficiaries about ten percent. The beneficiary premiums, unlike the Part B premium are going to vary depending upon the choice of the plan that you select, and that choice is going to be related to the plans that are offered in your region. There's another map that CMS has provided, which is different than the one that Linda showed you, but very similar, in that there are regions for the Part D drug plans and it will be the plans in your region that you choose from. We have heard from the CMS actuary that the expected cost is going to be about $3#7 a month for this premium, but that's a national average. The actual premium that individuals face could be 25 percent more or 25 percent less than that, depending on the region in which they live.

You hear a lot about the issue of solvency, particularly every year when the Medicare Trustees issue their report on the status of the Trust Fund. But the idea of solvency really only applies in a strict sense to the hospital insurance trust fund or the Part A trust fund. When we have a dedicated source of revenues, the payroll tax going for the

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specific set of expenditures, in other words, the Part A benefits. There is discussion at times about a Part B trust fund, but that fund will remain in balance because every year there's a transfer into the fund to cover the expenses that are going to be expected in the short term.

In this latest trustees' report, it was identified that we're going to exhaust the trust fund a little bit later than we thought in the prior year, in other words 2020, but that's still pretty close when you think about it, and that we're going to start to incur deficits in terms of the expenditures coming out of the trust fund, exceeding the income going into the fund in 2012. The overall Medicare financing question is of clear concern. Even though there may not be a strict Part B trust fund, there is a question of how much we are spending upon the Medicare Program. As you can see from this graph, we anticipate when we add Part D in 2006, we're going to spend a little over three percent of GDP, on Medicare. By 2035, with a lot of Baby Boomers having joined the program and incurring significant expenditures, we expect it to be up to about 7.5 percent of GDP. This kind of concern, and the question of how best do we deal with it led in the Medicare Modernization Act for the Congress to include a provision called the Medicare Funding Warning. This is a process whereby when the Medicare trustees identify that over the next seven years there's going to be a point where general revenue financing of Medicare

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exceeds 45 percent, and when they've done that for two years in a row, that they are supposed to announce to the world that this has happened. The President then is required to submit a proposal for remedial action, in other words, to bring the contribution of general revenues down below 45 percent, and the Congress is required to consider that on an expedited basis. There is no requirement, though, that anything actually happen. It's not like the debt ceiling, it's not like what will happen when Part A trust fund is exhausted. It's just that we're going to focus on this issue of where we are with respect to financing and is there something we can do about it?

Let's talk about how Medicare pays for services, and I'm going to focus on Parts A and B. Medicare is often criticized as having administrative prices, but I think we need to consider the reality of when you're a program as large as Medicare, what are your options? I mean, essentially the world divides up into three possibilities. You can be a price taker, a price negotiator, or a price setter. It's very difficult for Medicare to try and play the first two roles, given its size. If it's a price taker and the world knows that Medicare's gonna take the prices that are being offered to it, there's not going to be any discipline in terms of prices that are being offered to it. Sitting down to negotiate when we have close to a million providers is also another daunting task and was something that I'm sure Linda would verify CMS is not

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interested in taking on. As a result, we, in the most instances are in the situation where Medicare operates as a price setter, but a very interesting price setter, because it does use its leverage to try and have more information about setting those prices and trying to set those more efficiently. What we're doing today is in some respects very different from what we did at the very start of the program. It's maybe hard, given the popularity of Medicare today to realize that Medicare was vigorously opposed at the time of its passage and that part of the way that they compromise was reached in order to secure passage was that we agreed to, in terms of payment and providers to two seemingly innocuous concepts. We would have retrospective reasonable cost reimbursement and we would pay reasonable charges to other providers. Reasonables in both, so how could this be so bad? It turned out that both were incredibly inflationary, and that what we've been doing over the last 40 years is more slowly moving away from this method of payment. Today, probably the principal way that Medicare pays for most services is through prospective payment systems, and there's essentially a particular model for these prospective payment systems so that for any particular service there's very important and very significant variations in how the models apply. The essentials are that you have to establish a base payment for what you define as a unit of service. A unit in the hospital in terms of inpatients is an

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admission. In the nursing homes, in terms of the skilled nursing facility benefit it’s day of care. For home health services it’s 60 days worth of care, known as an episode. What we’ve done is use our leverage to get information from providers about the costs of delivering services and the national average cost is used as the base payment. Then adjustments are made to these base payments for the individual service being received by a beneficiary from a particular provider. There are adjustments for geographic variations, since the cost of labor and the costs of other inputs are going to vary tremendously as we move from one part of the country to another. There are adjustments for differences in the patients that are using particular services, patients that are admitted to a skilled nursing facility may range from someone needing rehabilitation and still have a fair amount of functioning on their own to people who are incredibly dependent and need an incredible amount of skilled nursing care. We also make distinctions in terms of the kinds of treatments that people are going to receive. People may be admitted to the hospital for a given condition, but some are going to be treated surgically and some are going to be treated medically, having greater impact on the costs that are going to be incurred. So we make adjustments for all of these in terms of trying to make payments fair and efficient for providers and for the program.

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In all of these systems, what we do is set the base rate historically based upon national average cost. You update this rate over time, both to deal with inflation and technological change. One of the roles of the Medicare Payment Advisory Commission is to examine data on what's happening with respect to provider payment and to provide the Congress information on how those updates should occur. This is a list of just some of the providers that were the prospective payment model is followed. There are materials in the handouts that I would refer you to that I think are excellent and you can actually get an update on some of those materials by going to the MEDPAC website in terms of the MMA adjustments.

Let's talk about some important exceptions to the prospective payment model. One of the biggest ones, obviously, is the physician schedule. There we have something which is called the resource-based relative value system. It's an exception because we don't know what the true costs of physician services are. The biggest cost of a physician's practice is the physician's income itself. It's very hard to get a sense of what is the appropriate measure of those costs, so instead, what we did when we implemented the physician fee schedule back in the early 90s is we said, "We have no access problem with respect to physician services, so we must be paying the right amount in that aggregate and what our job is going to be is we're going to distribute that right amount

across all of the different services that physicians supply. We did that allocation across all these different services by looking at what resources were involved in the performance or the delivery of any particular service, looking at three components: physician's work, the time, the skill, the training that was involved in that particular service, the practice expense, which is the staff, rent equipment and supplies that might be involved, and then an allocation of malpractice premiums across all kinds of services. We also, because of concern about the growth in the costs of physician services decided that in terms of updates what we should do is look at how expenditures are growing compared to what we thought was a tolerable level. This issue, for those of you who know Medicare well is what led to the sustainable growth rate, or the SGR, which is the source of so much discussion today, and we can talk about that some more in the Q and A period. The other exceptions I would note to the PPS model for Parts A and B are outpatient laboratory and durable medical equipment, where we've been living off not cost information but off of charge information from the 1980s that we've updated for inflation and subjected to certain limits, and we're now, because of the MMA going to try to move away from that, at least with respect to the durable medical equipment. We're going to start a process in 2007 to replace these fees based on old charges by using competitive bidding information that we

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get, and we're going to do this on an incremental basis by implementing it in a set of MSAs and grow the number of MSAs that we're doing over time. There's probably and endless list of issues in terms of Medicare payment policy. The idea of having an administrative system for something this complex—as I mentioned before, we have a million providers, about a billion claims coming in for Part A and B in a year, we've got 41 million beneficiaries with different service needs and trying to set up administrative pricing for all of that is incredibly complicated. So there's constant fine-tuning going on.

This is just a set of some of the issues that I think have been in our minds in the recent past or are very much in the forefront of our minds today. The sustainable growth rate for physicians, which is going to, because of a variety of factors lead to negative updates in physician fees over the next several years and is something that you've undoubtedly heard about. There's a great interest in paying for performance or quality since the idea of having flat fees which totally ignore quality seems totally untenable after 40 years. We need to think about how we adjust the relative payments across different services. This is the issue that underlies some of what is happening with respect to specialty hospitals. Access in rural areas was a big part of the MMA in terms of changing payment provisions to try and encourage better access and we've got payment for special purposes. Finally I can say

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the issue of managing program costs. I think we need to focus on this, but we want to focus on it from that perspective of managing costs and being an efficient purchaser, not simply the view of thinking about how to contain costs. We can never lose track of what the purpose of the program is, what we want it to accomplish, and then can we do that in the most efficient way possible? Thanks very much.

ED HOWARD: Thank you very much, Bill. We have now time for your questions, and I want to encourage you that this is a primer, this is a basics session. You should not feel at all put off by asking the most simplistic question you can imagine, because that's where we should be starting. Linda Fishman has to leave us in about ten minutes, so I want to encourage you to ask questions that might be directed most appropriately at her earlier in the session so that we can get the benefit of her expertise. Those of you who are in the room, there are three microphones, one up in front and two in the back where you can ask your question orally, and you have green question cards in your packets that if you will hold up someone will bring forward. One quick note for those of you who are in the congressional offices around the country, I remind you that you can e-mail a question to **frontdesk@allhealth.org** or call the Alliance at 202-789-2300. We have folks at each of the microphones. Let's start right here. Identify yourself and be as brief as you possibly can.

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DIANE DUSTIN: Hi, I'm Diane Dustin with Prudential Equity Group. This is a question for Linda. Trish mentioned that 13 percent of the population is served by Medicare Advantage and then she had another chart that showed that the private plans represent 15 percent of the Medicare costs, so in the new world, how will the government control those costs. I'm just a little unclear as to how the Medicare Advantage plans are going to get paid and how the government will get sure that it doesn't get out of control?

LINDA FISHMAN: Thanks Diane. Well, first of all, I guess I'd say the benchmark system against which plans bid will implement by its nature some predictability and stability as to what the government is going to pay. As I said, in MA local plans, that benchmark is determined through the statute, is not what I would call a truly competitive process, so there is some level of predictability and don't forget, if you're an MA local plan and your bid is over the benchmark, that means in order to attract beneficiaries, those beneficiaries will have to pay the difference between what the government pays and what that plan is charging its customers, so I would say that unlike the past, there may be effective mechanisms to control that.

ED HOWARD: I want to do a question if I can ask your forbearance at the microphones, that was submitted in advance by one of the folks in the field by e-mail. "The New York Times," this questioner writes, "recently had an article which

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said that elderly people with low incomes may lose some of their food stamps if they sign up for the new Medicare prescription drug benefit. Is this true?" And I guess, Linda, why don't you try?

LINDA FISHMAN: I'm on the hot-seat, huh?

ED HOWARD: Yes, you are. Yes, it is true that when a low-income beneficiary goes to determine his or her eligibility for assistance, food stamps and other government benefits will be figured into that calculation. However, it is very important to note that this benefit is so generous to those who are in lower income categories, we believe that you will be that much further off ahead, even if—I think the example was in the New York times that your food stamp benefit might go down by $10 but you may receive hundreds of dollars more in assistance and therefore be better off. It's just hard to help people understand that.

ED HOWARD: There may be people who—Oh, I'm sorry. Tricia, you want to respond to that as well?

TRICIA NEUMANN, Sc.D.: The only thing I wanted to say is maybe more of a question. I think that issue also came up in the transitional assistance, the $600 subsidy that went along with the discount card programs and in that case, CMS has some discretion to make sure that the $600 subsidy for low-income people did not count against other programs or food stamps. I don't think they have the same discretion under the law, so it

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would actually take an act of law to make this change to exempt other programs like food stamps from the value of the low-income subsidy under Medicare.

LINDA FISHMAN: Yes, that's correct, but one has to keep in mind that the prescription drug discount card was always thought of as a temporary program that would be replace by a full blown Part D drug benefit in 2006. The other thing was the drafters and supporters of MMA wanted to get the discount card up and running very quickly and so cast aside those kinds of points, but you're right, the law does not allow us to be so forgiving.

ED HOWARD: Yes, on the left.

BOB GUIDESS: My name is Bob Guidess [misspelled?]. I'm with the Infectious Diseases Society of America, representing infectious disease physicians. This is probably primarily for Linda. Under the MMA there was a provision to implement an average sales price methodology and phasing out the average wholesale price. For our physicians that has meant the antibiotics that they are infusing or injecting, they are now paying more for those drugs than they are being reimbursed. I'm wondering, I know the CAP program, the Competitive Acquisition Program is going to go into effect in 2006. Many of them may switch to that if they decide to continue taking care of Medicare patients. Has any of this discussion about the fact that physicians are being reimbursed lower than they

are paying for the drug come to your attention or the discussions with Congress about revising that or fixing that? And also, is there any discussion about taking the $300 million demonstration projects for oncologists and perhaps revising that to make it applicable to other physician groups so that they can address the fact that they're paying more for the drugs than they're getting reimbursed?

LINDA FISHMAN: Less than two hours ago I was visited by a physician specialty group, not oncology, who asked exactly the same question. This is uncanny! Yes, your point is well made. I would say that our administrator, Dr. McClellan has said that the demonstration would be a one-year demonstration program. I'm certain there is a great deal of interest in the Congress about extending it, but it does obviously cost a lot of money and we are in daily discussions about how the CAP program is going to work and the plight of doctors trying to deliver those services, so, thank you. The proposed rule for a physician payment will be out in July, so it is a very hot issue around CMS.

ED HOWARD: Yes, Sir?

JOE HAAS: Thank you. Joe Haas from CD Publications. I wanted to ask Bill Scanlon. I wanted to make sure I understood what you said about the premiums for the drug benefit correctly. Within a region, the premium will be uniform and will be set by the government, not by the individual plans?

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WILLIAM SCANLON, Ph.D.: No, it's the fact that the premiums are going to be set by the individual plans, so your choice of plan is going to determine your exact premium. But on top of that, because we do have the regions, the average premium in a region as we start to compare one region to another may also vary, so that was the point I wanted to make. I have no idea how much variation there is going to be within a given region, but across regions when one looks at the utilization of drugs historically and you see the variation, it would suggest that there maybe as much as about a plus or minus 25 percent at the extremes variation in premiums across region. Is that clear?

JOE HAAS: Not exactly. I thought you said that the premium was supposed to cover 25.5 percent of the benefit's cost.

WILLIAM SCANLON, Ph.D.: Of the standard benefit's cost, that's right, and it's of the specific plan that you joined.

JOE HAAS: But if the plans set the premiums, how do you get to that 25.35 percent? Aren't they going to set the premium to what they think is their market advantage? You know, try to underbid on another? "O, our premium is only $5 a month. They want you to pay 15?"

WILLIAM SCANLON, Ph.D.: Of the standard benefit for the region, and so if you join a less expensive plan, you are

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going to face a lower premium. If you join a more expensive plan you're going to face a higher premium.

ED HOWARD: Let me take another question from the field, if you will. "According to CBO and CMS, what percent of Medicare beneficiaries will participate in Part D, that is to say, the prescription drug benefit? And in your view, are those estimates reasonable, or I guess I should say, which estimate is reasonable?" Tricia?

TRICIA NEUMANN, Sc.D.: The CBO and CMS, the actuarials are actually quite close on their participation assumptions. They are both saying that roughly 29 of Medicare's 42 million people will be in a Part D plan in 2006 and most of the others will be in an employer plan, so their assumption is fairly full and complete drug coverage immediately next year. They are basing this assumption on Part B, where virtually 97 percent of all people who can sign up for Part B do so. The issue of participation is very important because both the CBO and the actuary are assuming with full participation they are assuming an average risk pool, and that's quite important for say, the premium question that was just asked, because if sicker people sign up first and come into the system before all people come in, then the average cost could go higher and premiums could rise, so this is a very important assumption, and if it indeed does come true, then some of the projection should be close to

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on target, but if sicker people come in first, then premiums could be substantially higher.

WILLIAM SCANLON, Ph.D.: I could just add, I agree with everything that Tricia said. I was part of a review panel for the Medicare Trustees Report this last summer, and this assumption by both CMS actuaries and CBO was one of the things that we considered. There is some concern about the differences between Part B and Part D that suggest that the outreach efforts that go on in terms of educating beneficiaries about Part D is going to make a big difference in terms of their participation. The differences are that for Part B you're automatically enrolled unless you opt out when you sign up for Part A, and Part D you have to take an active step on your own in order to become a Part D beneficiary.

The second thing is that we're not dealing with people that have only just turned 65, or have qualified for Medicare because of a disability, we're talking about the entire Medicare beneficiary population, which includes many people that are very old and may not be aware of the availability of this new benefit, so the idea that we're going to have high participation in terms of this being an attractive benefit certainly makes sense, but it's also going to be very important that the word get out to beneficiaries so that we achieve those levels.

TRICIA NEUMANN, Sc.D.: Tricia, quick.

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TRICIA NEUMANN, Sc.D.: I just want to add one thing, which is, this is a real concern in the next several months and in some of the survey work that the Foundation has done surveying seniors, we have found that a relatively small share of seniors say at this point that they are planning to sign up for Part D, and many of them don't know about the Medicare drug benefit, but obviously a lot needs to be done between now and next May at the end of the enrollment period to make sure that people who are eligible for Part D find out about it and sign up.

ED HOWARD: Linda?

LINDA FISHMAN: I have to chime in here because outreach is what CMS is all about. Not only is it a challenge to accept the bids from the plans and make sure they're good to go and get a lot of plans into the program, but the outreach efforts are substantial. We like to think about it in terms of five groups of people that we're trying to reach, and each one requires a different type of outreach strategy. For example, the Medicare Advantage enrollees. Now, those people are probably going to get their drug plan just by staying in their Medicare Advantage Plan. Employers – there are incentives in the MMA for employers to hold onto their drug benefits and wrap around Medicare with respect to drugs. The dual-eligibles that I spoke about are currently getting prescription drugs under Medicaid and they will be transitioned into the Medicare

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program, and how to work with states and make that transition run smoothly is a huge challenge for us. Reaching out to the other low-income folks who could benefit by such a benefit requires yet another strategy and then finally, how about the people who don't have any coverage at all or especially frail people where adult children, for example, may be making those decisions on behalf of their parents or other loved ones. Each of those groups requires a different strategy and we're working hard to develop that kind of strategy, and it will require the cooperation and assistance of the Congress as well. I have to put that plug in, and we'll get back to you on that.

ED HOWARD: And we're going to try to see if we can't arrange another program through these auspices to try to attack some of those questions closer to the educable moment when the sign up period will be open. Yes, back in the back.

HENRY CLAYPOOLE: Yes, I'm Henry Claypoole, and I'm actually here as a private citizen today. My question is—two questions. One is, how many people with Medicare are living with a disability or chronic health condition and, I think the followup question is really for Bill, and that is, as that number increases, is the current benefit structure in fee-for-service what drives all the payments that are going to private plans, is it really going to adequately respond to their needs in the appropriate settings to maintain their health in a cost-effective manner? I'll listen, please.

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TRICIA NEUMANN, Sc.D.: Looking at how many people on Medicare of all ages have a disability is a little bit of a tough question, because it depends on how you define chronic condition or disability. Two-thirds have one or more chronic condition, so that's a measure. A quarter are in fair or poor health. That's a different way of measuring it, and a quarter have cognitive impairment, so I guess the point is, a very large segment of the Medicare population, elderly and non-elderly, live with serious disabilities and they have very different needs depending upon their disabilities. So, for example, people who are under 65 have a very high prevalence of mental conditions and disabilities which means that their care needs differ significantly from those with other forms of disability. Maybe you could handle the second form of question.

WILLIAM SCANLON, Ph.D.: I think in terms of the Medicare benefit package that we do sort of need to think about the suitability of it for a population with chronic illnesses as well as for disabilities, and I make some distinction between the two because I think that in terms of management of a chronic illness, the idea that you have access to any providers within the healthcare community is potentially a good thing, but the lack or coordination among those providers can be problematic and we need to think about how it is that we can introduce the good coordination that will help with chronic

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conditions. We have a pilot right now that's being started with efforts in that regard. I frankly don't know the details of what individual organizations are going to do in terms of trying to assist in the management of care, but I think this is something that we have to watch carefully to see if there are models that we would like to see emulated and disseminated more widely.

The second issue, though, is this question of dealing with some of the consequences of disability and the kinds of services that supplements for that disability, which are popularly known as long-term care. I think we need to have a discussion and first of all, let's not criticize Medicare for not covering long-term care, because it was never in the benefit package, but we need to have a discussion about how are we going to finance long-term care in the future, and make decisions in terms of what is the best way to approach that. Those kinds of supportive services to deal with the loss of ability to perform activities of daily living or instrumental activities of daily living are critical and right now, the only significant source of third-party financing for that are Medicaid programs. The good news can be that you're on Medicaid and the bad news can be that you're on Medicaid. One of the studies that we did at GAO pointed out the great variability in the kinds of services that you might be able to access once you're Medicaid eligible and have a disability, and

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the range was so great, you really questioned what were going to be the consequences for individuals with similar levels of disability in different circumstances.

ED HOWARD: Yes, in the back.

FRAN CHRIS: Fran Chris, New York Daily News. My question is for Tricia Neumann who has answered about a million of my questions in the last few days. In Medicare Part D, if you sign up for a plan and you are able to find all the drugs that you need in a particular plan, but two months later your doctor prescribes another drug and that's not in the plan, can you opt out each month? How would you redesign your personal plan so that now all of your drugs within a year are being covered?

TRICIA NEUMANN, Sc.D.: No, the general model for Part D is that once you are in a plan you stay in that plan for the remainder of the year. In some respects it's modeled along the federal employees' health benefits plan where you can't opt in and opt out, so that is a fundamental change for the Medicare HMO plans that are out there today, where seniors at least for now can leave their plan if they want to go to another plan for a different drug benefit or if they reach their cap. So that just has to be part of the thinking for people. During the enrollment process they really need to make their best judgment, but if they get a notice from their plan midway through the year that they're no longer covering their

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prescription, they would need to go through formal appeals process in order to get the plan to provide them that prescription, or if they succeed, they may be able to get it, but if not, they would go without and have to start the search over at the beginning of the next year.

FRAN CHRIS: But you could appeal? That means that let's say, you're taking three drugs and suddenly the doctor adds a cholesterol lowing drug that isn't covered, they say no, at least there is an appeals mechanism.

TRICIA NEUMANN, Sc.D.: There is a process.

FRAN CHRIS: The doctor can say why it's needed. Okay.

ED HOWARD: I want to just remind people that we would very much like you to fill out those blue evaluation forms as we finish up the program here, and those of you who are listening and watching in state and district congressional offices, there is that, in addition to the form that we sent to the office an online questionnaire that you can fill out to help us make these programs even better. Let me just ask a quick question from one of those offices that got submitted via card. Very straightforward. "Are Medicare Part D premiums deductible by the payer on Schedule A of Form 1040 or on any other schedule?" Tax experts, anybody? I should say, Linda Fishman has left us and has offered to the extent that we get questions that we don't get answered or don't get to asking, to respond in writing and to the extent that that is the case, we

will post those questions and answers on our website. And if we have no tax experts in the audience who ought to be encouraged to come to the microphone, we'll move to the microphone. Allen?

ALLEN WEST: Yes, Allen West with Senator Biden. I have two quick questions. First of all, the different structures of Part A and Part B as I understand it, that goes back to 1965 when they were modeling Part A after Social Security and Part B after Blue Shield. Does that difference still serve any function? And my second question is a useful function? My second question is, you outlined the problems with the trust fund, and as I understand it, some of the interest on the trust fund is already going to pay benefits from the HI trust fund. We see a lot on TV about televised conferences about how to fix Social Security, which is in good shape for another 40 years, but Medicare is going to have trouble a lot sooner. Is anybody working on how to solve the financial problems of Medicare?

ED HOWARD: Is anybody working on the financial problems of Medicare? At MEDPAC, perhaps?

WILLIAM SCANLON, Ph.D.: There's certainly been work on it. The question is, is there progress that we can report on it? In terms of your first question, whether it still makes sense to have a Part A and a Part B, I think we can maybe focus on the word still, because there may be a question of whether

it ever made strong sense other than politically to have the bills passed. Frankly, I mean, most of the time when people are thinking about Medicare, it in some respects gets in the way of thinking about it because we think about it as a uniform program. Unfortunately, in terms of beneficiaries' experiences, the fact that most have signed up for Part B sort of makes it much more of a sensible program in determining this broad coverage. And the distinctions between the two parts in some respects are relatively arbitrary. As part of the Balanced Budget Act in terms of trying to improve the status of the Part A trust fund, some of the home health benefits were moved from Part A to Part B. That same kind of thing could be one of the ways that we deal with the Part A trust fund in the future. There's no question that this long-term control over Medicare costs is of grave concern. The question really is of how we define a way to do this while still fulfilling the program's intent to provide coverage for beneficiaries. In the mid-90s I think we felt very heady about our ability to control costs when managed care was more in its heyday, and it looked like we were going to be able to be very successful in limited growth in costs, and we wouldn't have nearly the problem that we've had. We've had a variety of backlashes from that period of time and we've seen now both increases in terms of the price of services as well as the use of services, both of which represent significant problems. At the first step I think one

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of the things we need to think about is the variation in service use across the country. There's more and more word from the clinical side saying high levels of utilization in parts of the country just don't make sense. They're not beneficial to individuals receiving the services. What can we do to change that in a way that people get the needed services but they don't get unnecessary services and we see some of those services are correlated with the supply of providers that are in different parts of the country?

The second thing, which I think is a MEDPAC focus that we need to keep in mind is we need to be asking ourselves the question, are we paying efficiently? Are we paying just what it needs to get providers to provide these services as opposed to paying so much that everybody is too happy to be a Medicare provider? And while you hear about that there's a threat to access to services, the reality is that at this point we have a very good participation of providers, almost universal for some types of providers, and I'm not advocating that we cut significantly so that we reduce that participation, but I think we need to know or be willing to think at times about can we constrain some of their increases in fees and that we will find that providers are still willing to participate in this very important program from their perspective.

ED HOWARD: Yes, go right ahead.

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JORENE GALLIANO: Hi, Jorene Galliano, House Energy and Commerce Committee. I just have a question regarding beneficiaries that are currently on Medicaid but not Medicare or Social Security. Will they be contacted saying, "Your drugs are not going to be paid for anymore by the state and now you need to enroll in Medicare?" or how does that work? Do they automatically get enrolled in Medicare? And then, do they still have the same coverage under Medicaid for all their doctors' visits and everything. I'm just thinking more particularly about disabled beneficiaries.

ED HOWARD: Disabled beneficiaries who are not on Medicare?

JORENE GALLIANO: Correct. Right now, I'm thinking of some that are just on Medicaid and it's because they're completely uninsurable because they have so many health concerns and they primarily get all their medication through Medicaid.

ED HOWARD: Tricia?

TRICIA NEUMANN, Sc.D.: They will be contacted by the Centers for Medicare and Medicaid Services. They have the primary responsibility for getting in touch with people who are now getting their drug coverage paid for by Medicaid. Some states will also be involved and feel it's important for them to do more in terms of reaching out to people who now receive their coverage under Medicaid because when the shift occurs,

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those folks may well turn to their state and say, “Hey, what happened to my Medicaid benefits?” But the idea is that the Centers for Medicare and Medicaid Services will let them know that this change is coming by the end of the year. They will also automatically enroll them into one of the Medicare drug plans in their area—These would be the plans that are at or below the average premium—and notify the individual as to which plan they have been assigned to. Now, there have been a number of questions and concerns raised by patient advocates and those who do a lot of work with the dually eligible population that you’re talking about, and in response, CMS has tried to come up with some plans that will help to stop there from being gaps in coverage, because the worry is that not all of the nearly seven million people who get their Medicaid will make this transition smoothly, and if they don’t make this transition smoothly, there could be problems that emerge in January when they go to fill their prescription and find at the pharmacy that the pharmacy doesn’t take their card. CMS is trying to put into place a computerized system at pharmacies so that if people don’t bring their correct new Medicare Part D prescription drug plan to the pharmacy, the pharmacy should know which plan that person is in and which plan should be billed and so they will fill the prescription, but a lot needs to be done to make sure there aren’t any gaps and people don’t fall through the cracks. As Linda said, it’s a complicated process and a new challenge

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for CMS to work so closely and so quickly with states to make sure this happens relatively smoothly.

The other question that you asked was, will they continue to get their benefits, both under new Medicare drug plans, but also their other Medicaid benefits from Medicaid? They should—as long as long as they know they are still in Medicaid for benefits other than prescription drugs—get those benefits from Medicaid without any change. There is a question as to whether or not they will be able to maintain their prescription drug regimen under the new Medicare plans, and in that respect, they're much like other Medicare beneficiaries who sign up for a prescription drug plan, in that it's not clear which drugs will be covered by those plans and so that's a very important question. There is some help being provided to duals because they will be automatically assigned to a Medicare drug plan, but they still should look to see whether the plans are going to cover their prescriptions, and might want to switch plans and not just stick with the plan they've been assigned to.

ED HOWARD: Let me just try to clarify here, because sometimes I hear something different from what people say, and sometimes different answers, but what you just described was the situation for people who are now on Medicare and are getting their prescription drugs through Medicaid. I thought

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part of your question anyway, referred to people who were not on Medicare at all now—

JORENE GALLIANO: Right, right. The group of people I'm thinking about—

ED HOWARD: —but were getting drugs and other services through Medicaid.

JORENE GALLIANO: Just Medicaid, so are they considered a dual eligible if they're just Medicaid now?

TRICIA NEUMANN, Sc.D.: That group of people shouldn't be affected by the Medicare legislation because if they're not on Medicare, this would not affect them.

JORENE GALLIANO: Right. But Medicaid's not going to pay for their medicines anymore, so they'll have to go—

TRICIA NEUMANN, Sc.D.: That's a great question, particularly now that I understand it. Medicaid will continue to cover prescription drugs for those who are on Medicaid but not on Medicare. It's only for the group of people who have Medicare that will be shifted from Medicaid to Medicare.

JORENE GALLIANO: Okay. Thank you.

ED HOWARD: A question here. How will the new income-related premium under Medicare work? This is the Part B premium, I guess? Bill?

WILLIAM SCANLON, Ph.D.: It's going to be for individuals with adjusted gross incomes of over $80,000 and couples of over $160,000 and it's going to be a graduated

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increase in the premiums so that individuals with incomes over $200,000 and couples over $400,000 will end up paying about 80 percent of the Part B costs as their premiums. It's going to be phased in over a five-year period, I think it is, and there's going to be a transfer of information from the IRS to the Social Security Administration in order to be able to administer this. We're talking about a very small fraction of Medicare beneficiaries who have incomes over $80,000 or $160,000 for a couple, so it's not a large group of people at all.

ED HOWARD: Here's a question about perceptions, I guess. "Most Americans," this questioner writes, "think they pay for Medicare through the payroll tax over a lifetime of work. In that case, why is there any Part B or Part D premium or general revenue contribution at all?"

WILLIAM SCANLON, Ph.D.: Well, most people are right in that they are paying for Medicare and they are paying it through the payroll tax, but the revenues that are coming in through the payroll tax are dedicated to pay for just a portion of Medicare benefits, the Part A benefits. If you look at all the dollars that come into Medicare together, the payroll tax covers about half, a little bit less than half of the total, the rest would be general revenues and premiums. So pretty much, the other dollars are needed because the payroll taxes

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wouldn't be sufficient to cover all the benefits, and that's the way the program was originally designed.

There's also an aspect of this which is that the money that we pay in during our working life, at least historically for people, does not cover their benefits throughout their life because of the fact that medical inflation has been so significant and increases in use have been so significant that the actual payout from Part A for the average individual has been exceeding their contribution to it. In that way, it's a system that's very similar to the Social Security system in that in some respects you're buying through your payroll tax your participation in this system where future generations are providing an exchange, your benefit, and they in turn hope that another future generation will provide theirs.

ED HOWARD: Yes?

PAM ROBERTO: Hi. Pam Roberto with GAO. I'm wondering what, if any, incentive private insurers will have to continue to offer Medigap H, I and J plans after next year? And what happens to current Medigap enrollees if their plans are discontinued? Will they then be assessed the late enrollment penalty if they decide to join Part D?

ED HOWARD: And do I understand correctly that the H, I, and J plans are the ones that have a prescription drug benefit? Is that right? Okay. Tricia?

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TRICIA NEUMANN, Sc.D.: Medigap issuers can continue to sell H, I, and J and people who have H, I, and J can renew their policies. People who don't now have these Medigap drug policies won't be able to buy them, but the drug benefits that are covered under Medigap H, I and J packages are not equivalent to the Medicare drug benefits, so if someone retains their Medigap prescription drug policy from their Medigap provider and subsequently decides to sign up for the Medicare drug benefit because maybe their premium went up of they realized it wasn't as good coverage as they could get under Medicare, they would pay a penalty for late enrollment.

And as for the incentives in the Medigap market, you know, there are still other benefit packages that are the most popular benefit packages, so there may be incentives to continue to offer the basic package. C is the most common, which doesn't provide prescription drugs and many people on Medicare are fairly risk averse, and so seem to be attracted to policies that help them manage their costs on a more monthly basis.

ED HOWARD: Very few people buy the H, I, and J policies, as I understand it.

TRICIA NEUMANN, Sc.D.: Right, the most common policy is C, which doesn't cover prescription drugs.

ED HOWARD: And in a different life when I worked for the House Aging Committee those prescription drug benefit plans

were perceived by at least some of the senior organizations as not being a very good deal. Is that a fair characterization? I don't want you to make a blanket statement that's not generally true, but the question of the appropriateness of these plans continuing whether or not there's a Medicare drug benefit has risen in some of the sessions that we've had.

WILLIAM SCANLON, Ph.D.: Without passing any aspersions, I mean, it is true, these are individually marketed policies for the most part, and as a result the administrative costs are quite expensive, and so you end up maybe paying 30 percent or more of your premium for administrative costs, so in that respect they're not a good deal, and on top of that, as Trish indicated, it was quite a limited drug benefit, and in particular, when you're now facing the choice of a Part D plan, it's not even a question of there being any choice. You would immediately think about what is your best Part D option.

ED HOWARD: Yes, go right ahead.

JULIE CROUDER: To follow up on the one percent penalty—

ED HOWARD: Would you identify yourself, please?

JULIE CROUDER: I'm sorry. Julie Crouder with the American Health Quality Association. The one percent penalty, does the payment for that go back to the plans, or does that go back to the trust fund? The late enrollment penalties? Who benefits from late enrollment?

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TRICIA NEUMANN, Sc.D.: There may be a collection through the plan, but the idea is it goes back to Medicare.

JULIE CROUDER: Thanks.

WILLIAM SCANLON, Ph.D.: And to the extent that there is some adverse selection in terms of people either needing more drugs or fewer drugs that are signing up later, there will be some adjustment, because the plans are going to be paid both on a risk adjusted basis and then there's some risk-sharing in the early years of the plan experience, so ultimately, they may end up with a very indirect benefit here.

ED HOWARD: We have just a couple minutes left, so if you—and I have tons of cards up here, so we're not going to get to all these questions, so if you want to have your question asked, you better get to a microphone. In the meantime, let me just take a couple related questions that have to do that are particularly, actually relevant to some of our friends in the state and district offices. "There are a number of states that have prescription drug programs for seniors and others. Will those states continue to offer these programs after Part D becomes available? And if they do continue it, will people be able to sign up for both the state programs as well as Part D? Will states be able to buy their folks into Part D? How is this going to work?"

TRICIA NEUMANN, Sc.D.: The short answer is, I don't think we know the answer to that, because a lot of the states

are still trying to sort through what they're going to do with their pharmacy assistance programs. The person who sent in the question is right. They've been an incredibly important source of assistance to people, mostly in a small number of states where the help has been concentrated, but all the states now are trying to think through how they can and should maintain their programs.

ED HOWARD: Well, we've just about come to the end of our time here, so I'm going to urge you once again to fill out those blue evaluation forms if you're sitting here or sitting with the form in the Congressional Office, those of you in the Congressional Offices can fill out an evaluation online. We will try to post the answers to questions that we haven't gotten to on our website within a few days. Keep watch for that. And I ask you to join me in thanking not only the Kaiser Family Foundation for its support and participation, but our panelists, including the now absent Linda Fishman for what I hope was a very useful exercise in covering a number of important topics on this complicated subject. Thank you.

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