MEDICARE AT A CROSSROADS:
THE GORE-LIEBERMAN PLAN
CONTENTS

Overview: Medicare at a Crossroads 5

Chapter 1: Medicare: A History of Success, a Future of Challenges 11

Chapter 2: Protecting Medicare 19

Chapter 3: Improving Medicare 27

Chapter 4: Modernizing Medicare 45

Chapter 5: A Different Path: The Bush-Cheney Approach 57

Notes 71
OVERVIEW: MEDICARE AT A CROSSROADS

For over 35 years, Medicare has provided vital health care coverage to America’s senior citizens. For 39 million seniors and people with disabilities, Medicare provides the peace of mind in knowing that the prospect of illness will not mean the prospect of poverty. Medicare has contributed to lowering poverty among seniors, which has dropped by almost two-thirds since 1965.

Before Medicare was established, 44 percent of seniors had no health care coverage. Today, virtually all seniors know that they can count on Medicare covering the care they need, and providing the dignity they deserve. Medicare affords dignity for people with disabilities, and it has provided countless families the peace of mind of knowing that Medicare would be there to help them care for their own parents.

The challenge of the older generation was to put Medicare in place, to ensure that their parents had the health care they needed. With the retirement of the baby boom around the corner, and the race of new technologies and new medicines, Medicare stands at a crossroads. It can be strengthened and modernized to deal with these new challenges, or Medicare can be undermined to the point of becoming ineffective. The two candidates for President have very different approaches to what they would do with Medicare at this pivotal moment.

The Gore-Lieberman Plan

Al Gore and Joe Lieberman have a plan to help Medicare through this critical moment, by protecting, improving, and modernizing.

• Protecting Medicare. Al Gore and Joe Lieberman will pursue a fiscally conservative approach, that:
  ▪ Takes the entire Medicare surplus ($360 billion over ten years) and places it in a “lockbox;”
  ▪ Ensures that Medicare payroll taxes only go for Medicare and paying down the federal debt;
  ▪ Uses the interest savings from debt reduction to keep Medicare solvent until at least 2030.
• **Improving Medicare.** A Gore-Lieberman administration will improve Medicare to make it better reflect the state of medicine today, and better serve its beneficiaries. Al Gore and Joe Lieberman will add to Medicare:

- A voluntary, affordable prescription drug benefit that would cover all seniors and people with disabilities under Medicare;

- A proposal to allow vulnerable 55-65 year olds to buy in to Medicare;

- A plan to ensure that seniors use the most up-to-date prevention tests – by eliminating co-payments and deductibles for many screening tests and by making sure Medicare covers the state-of-the-art preventative care.

• **Modernizing Medicare.** Al Gore and Joe Lieberman will bring Medicare up-to-date by:

- Letting seniors – not HMOs – make (and benefit from) choices about their health coverage;

- Making sure that seniors can choose their own doctor, the medicine that their doctor recommends, and the health plan that makes sense for them – whether it is traditional care or managed care;

- Increasing price competition;

- Cracking down on fraud and abuse;

- Introducing new management and efficiency techniques to give Medicare the same tools that private insurance has to improve quality and efficiency;

- Protecting choice by increasing penalties for HMOs that drop seniors and by cracking down on HMOs that just cherry pick healthy seniors.

The result of the Gore-Lieberman plan would be a Medicare program that is stronger and more solvent than it is today; that provides more comprehensive quality coverage than it does today; and that offers seniors more choices. Al Gore and Joe Lieberman preserve the best things about Medicare today, while also improving and modernizing it to deal with the challenges that will confront Medicare tomorrow.
Moreover, the Gore-Lieberman plan takes other steps to improve Medicare and expand the choices it offers. It does so by making it harder for HMOs to drop seniors while increasing penalties on those that do; by forbidding “cherry-picking” that leaves some seniors without quality choices; and by working with state regulators to develop new, more affordable and accessible Medigap insurance options.

In sum, Al Gore and Joe Lieberman recognize that Medicare must change before the baby boom retires – but as a nation, we must not lose our fundamental commitment to a national system of health coverage for seniors. The Gore-Lieberman plan makes those changes, while also keeping that commitment.

The Bush-Cheney Plan

George W. Bush and Dick Cheney’s approach is very different. Governor Bush has referred to Medicare derisively in a recent television advertisement as a “government-run HMO.” Some of his approach to Medicare reflects a return to the oldest Republican alternatives to Medicare in the first place – relying on state-run programs, or private insurers, instead of a national insurance system for seniors.

Specifically, the Bush-Cheney plan would take a very different course for Medicare, by:

- **Raiding the Medicare surpluses.** The Bush-Cheney plan has no Medicare lock-box. In fact, it takes $360 billion in taxes paid into Medicare and diverts 72% of them to a tax cut, almost half of which goes to the wealthiest one percent of Americans.

- **Providing inadequate prescription drug coverage.** Bush and Cheney offer a prescription drug plan that relies on state welfare systems to provide benefits – a plan that is projected to cover only 625,000 seniors (and no one who makes more than $14,600 per year) even though 13 million beneficiaries – from all income brackets – now lack coverage and millions more have inadequate, unreliable coverage.

- **Forcing seniors into HMOs.** The Bush-Cheney plan will raise premiums in traditional Medicare – forcing seniors out of traditional coverage, into managed care plans, even when that is not what they want.
Taken together, the Bush-Cheney plan erodes Medicare, by gradually placing more of the benefits, more of the funding, and more of focus, on state welfare and private insurance providers. The plan is consistent with an approach taken by many Republicans. This was expressed recently by House Budget Committee Chairman John Kasich, who said that many Republicans were “moving in the direction of . . . a voucher” in lieu of today’s Medicare guaranteed coverage.

The Consequences of the Bush-Cheney plan

What are some of the consequences of the Bush-Cheney approach?

- **Higher premiums forcing seniors into managed care.** The failed Medicare Commission ‘premium support’ proposals that Governor Bush has endorsed would raise premiums by 18 to 47 percent, according to Medicare’s own actuaries, forcing many seniors who cannot afford those increases into HMOs, even if they do not want to change their coverage.

- **Higher Medicare taxes or benefit cuts in the future.** By draining away Medicare monies to pay for his tax cut plan, Governor Bush will leave Medicare unable to meet its obligations when the baby boom retires – that means higher Medicare taxes, or deep benefit cuts in the future;

- **Seniors sent through welfare offices for drug coverage.** The Bush prescription drug plan – until 2005 – relies on state low-income drug subsidy plans – plans that leave out most seniors, and require (in some states) seniors to contact welfare offices to sign up for coverage.

- **Benefits that vary from state-to-state.** The Bush-Cheney plan would create a situation where a senior’s health benefits and eligibility vary from state-to-state – despite the fact that taxpayers in every state fund the plan.

Conclusion

The difference of opinion over Medicare is a legitimate one – but a significant one, too. On one path, Medicare would be prepared for the baby boom’s retirement, strengthened, improved, and modernized. On the other path, today’s Medicare system would be replaced by a splintering of the plan, with countless seniors left to fend for themselves, and millions placed at the whim of private insurers.
The following pages lay out the Gore-Lieberman approach in detail – with specifics about what they would do to protect, improve, and modernize Medicare – and what they will not do, as well. We hope the Bush-Cheney campaign will do the same. But even with what we know thus far, we know that the two campaigns have very different plans for what to do with Medicare at this crossroads.
CHAPTER 1
MEDICARE: A HISTORY OF SUCCESS,
A FUTURE OF CHALLENGES

In July of 1965, President Lyndon Johnson flew to Independence, Missouri to sign the Medicare program into law. He wanted to share this accomplishment with Harry Truman, who had tried, but to no avail, to pass a health care program for the elderly. Since that emotional day in Missouri 35 years ago, Medicare has had a profound effect on the lives of millions of Americans.

Prior to its creation, the prospect of illness meant the prospect of poverty for many seniors. Since its enactment, Medicare has provided access to quality health care for those Americans least likely to be attractive to private insurers – not only the elderly, but also individuals with disabilities. It has freed them and their families from the burden of expensive medical bills, enabling many to live full lives well into their golden years.

When the Clinton-Gore Administration came into office, Medicare was on life-support, projected to become insolvent in 1999. Because of hard work and hard choices, Medicare is projected to stay solvent until 2025. But now is no time to rest. Medicare needs to be strengthened and modernized for this age of incredible medical advances. Al Gore and Joe Lieberman understand this, and are committed to keeping Medicare solvent and suited to meet all the challenges it faces.

I. MEDICARE: IMPROVING THE LIVES OF SENIORS AND AMERICANS WITH DISABILITIES

Today, 39 million seniors and people with disabilities depend on Medicare for their health insurance. For them, and for all of America, Medicare has meant an improvement in life expectancy and a decrease in poverty. Its effects have been felt in every community in every state in the Union.

Medicare’s Impact on America

In 1964, nearly half of all seniors were uninsured. Today, 97 percent of seniors have health care coverage. ¹
Medical advances and technology, improved nutrition, and higher standards of living are contributing to increased life expectancy. But so too is the health care that Medicare provides. Since 1965, the life expectancy of people who reach age 65 has increased by 20 percent, from 79 to 82 years. In 1965, a 65-year old American woman could expect to live an additional 16.3 years, reaching the age of 81.3. In that same year, a 65-year old man could expect to live an additional 12.9 years, reaching the age of 77.9. Since then, life expectancy has increased dramatically. Today, a woman reaching the age of 65 can expect to live another 19.2 years, to the age of 84.2—a 20 percent increase. And the average 65-year old man lives to the age of 80.9, or three years longer than in 1965.\(^2\)

Medicare has also helped give the elderly the dignity they deserve, by keeping millions from becoming impoverished as a result of illness or disability. In 1964, more than one in three Americans over 65 were living below the poverty line—more than double the rate of those under 65. Today, in part because Medicare guarantees health security, the poverty rate for the elderly has fallen to approximately one in ten—a rate lower than that of the general population.\(^3\)

Often overlooked, but no less important to its mission, Medicare provides a bedrock guarantee of health insurance to Americans who are or become disabled. In
1972, Congress extended Medicare coverage to individuals on Social Security Disability Insurance (SSDI) and those with end-stage renal disease (ESRD). Since the beginning of the ESRD program, over one million Americans have received life-saving renal replacement therapy, either through dialysis or kidney transplantation. For these vulnerable Americans, Medicare provides the same protections against poverty and the same quality of life enhancements as it does for the elderly. It provides peace of mind for all Americans that if they face a serious disability, Medicare will be there.

Medicare is especially important to women, not just seniors, but also middle-age women who often care for their elderly parents. Women comprise nearly three out of every five Medicare beneficiaries. In fact seven out of ten Medicare beneficiaries with income below poverty are women, and they are much more likely to have chronic illnesses that require medical attention. For instance, older women are three times as likely to use Medicare’s home health benefit which allows them to receive long-term care at home. In addition, the ones often caring for elderly or ill relatives, and thus benefiting with any help with giving this care, are women too.

It must also be noted that since its formation, Medicare has had a large impact on seniors of color. In 1963, many African-Americans and members of other racial and ethnic minorities were subjected to substandard care or were simply denied medical care outright. By requiring that hospitals participating in the program cease discriminatory practices, Medicare set a powerful example, and had a powerful impact. In 1963, minorities averaged 4.8 visits to the doctor; by 1971 their visits grew to 7.3, a number comparable to Caucasian doctor visits. Currently, 7.3 million individuals who are African-American, Hispanic, Asian, and Pacific Islanders rely on Medicare for health insurance.

**Medicare: An Integral Part of the Nation’s Health Care System**

Covering approximately 14 percent of the population and financing about 21 percent of the nation’s health spending, Medicare plays a critical role in supporting and shaping American health care. Medicare payments are vital to the nation’s health care providers: 5,294 hospitals (including 1,379 rural hospitals and 1,124 teaching hospitals), 7,426 home health agencies, and 14,829 nursing homes. Medicare provides special support for the inner-city and rural health care facilities that serve a disproportionate number of uninsured and low-income patients. In fact, Medicare spends nearly $4 billion on its “disproportionate share hospitals” program that helps hospitals that help low-income populations. It also has a number of policies and special payments to ensure the viability of rural health care providers, including sole
community providers, rural health clinics, and other essential providers that make up the critical and frequently only health care infrastructure in rural communities.

Medicare also demands a high standard of quality and safety from all of its providers. Despite Congressional inaction, the Clinton-Gore Administration took executive action to apply all possible patient protections to the Medicare program. In turn, this set a standard for communities across the country, encouraging health care providers across the country to provide high-quality services to all of their patients.

II. IMPROVING MEDICARE: THE PAST EIGHT YEARS

The Clinton-Gore Administration has taken strong action to enact Medicare reforms that extended program solvency; cut down on fraud, waste, and abuse; provided important new preventative benefits to beneficiaries; and added new plan choices.

Extending the Life of the Medicare Trust Fund 26 years – Until 2025

When Bill Clinton and Al Gore came into office, Medicare was projected to become insolvent in 1999. But the Clinton-Gore Administration has been a responsible steward of Medicare. Its aggressive and successful efforts to combat fraud, waste, and abuse, combined with a strong economy and reimbursement reforms have brought about the longest Medicare Trust Fund solvency in a quarter century. They extended the life of the Medicare Trust Fund by a total of 26 years so that today, it is projected to be solvent until 2025.

This has had an immediate impact on beneficiaries today. It is in large part due to these efforts to extend solvency that Medicare now offers premiums that are nearly 20 percent lower now than projected in 1993.

Implementing New Structural Reforms to Modernize the Program

The Clinton-Gore Administration implemented a series of structural reforms that modernized the program, bringing it in line with the private sector and preparing it for the baby boom generation. These reforms: increased the number of health plan options; launched a new beneficiary education campaign to improve informed choice; implemented prospective payment systems for skilled nursing home facilities, home health, and hospital outpatient departments; and adopted private-sector oriented purchasing strategies.
Fighting Fraud, Waste, and Abuse in Medicare

Since 1993, more federal prosecutors and FBI agents have been assigned to fight health care fraud than ever before. As part of the 1996 Kennedy-Kassebaum legislation, we now have a new stable source of funding to fight fraud and abuse. As a result, convictions have gone up a full 410 percent, saving more than $50 billion in fraudulent health care claims. And since 1996, nearly $1.6 billion in fraud and abuse savings has been returned to the Medicare Trust Fund.

Strong Action to Remedy the Reimbursement Concerns of Health Care Providers

In order to address imperfect policy constructions and excessive payment reductions resulting from the Balanced Budget Act of 1997, the Clinton-Gore Administration advocated strongly for the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act (BBRA) of 1999. This legislation invested over $16 billion over five years to moderate the impact of the BBA by placing a moratorium on therapy caps; increasing payments for very sick patients in nursing homes; restoring funding to teaching hospitals; and easing the transition to the new prospective payment system for hospital outpatients.

Creating New Preventative Benefits

The Clinton-Gore Administration enacted legislation to cover important preventative benefits. This included waiving cost-sharing for mammography services and providing annual screening mammograms for beneficiaries age 40 and older to help detect breast cancer. It also established a diabetes self-management benefit; ensured Medicare coverage of colorectal and cervical cancer screening; ensured coverage of bone mass measurement tests to help women detect osteoporosis, and increased reimbursement rates for certain immunizations to protect seniors from pneumonia, influenza, and hepatitis. However, it should be noted that many of these benefits still require cost sharing, which can prevent beneficiaries from getting these services.

Limiting Beneficiary Hospital Outpatient Cost-sharing

The Clinton-Gore Administration advocated for the reduction of the Medicare beneficiary coinsurance payment for hospital outpatient department services from its current approximately 50 percent of costs to 20 percent over a
number of years. This limited the amount of coinsurance that a beneficiary pays for outpatient care to the Part A deductible ($776 in 2000).

**Reimbursing Providers to Support Patients in Clinical Trials**

Today, too few patients participate in clinical trials that can provide access to life-saving therapies. At the same time, with fewer people participating in trials, scientists are hindered in their development of these drugs and therapies. That is why the Clinton-Gore Administration directed the Medicare program to revise its payment policy and immediately begin to reimburse providers explicitly for the cost of routine patient care associated with participation in clinical trials. Moreover, the Department of Health and Human Services was directed to take additional action to promote the participation of Medicare beneficiaries in clinical trials for all diseases. These included: activities to increase beneficiary awareness of the new coverage option; actions to ensure that the information gained from important clinical trials is used to inform coverage decisions by properly structuring the trial; and reviewing the feasibility and advisability of other actions to promote research on issues of importance to Medicare beneficiaries.

**Expanding Assistance for Low-income Medicare Beneficiaries**

To help our communities’ neediest, the Clinton-Gore Administration extended coverage of the Part B premium for low-income individuals, so that all of those with income below 135 percent of poverty (about $15,000 for a couple) do not have to pay premiums. It also launched education campaigns and other efforts to increase awareness of this assistance.

**III. MEDICARE AT A CROSSROADS**

It is undeniable that Medicare is a success story. However, as we enter the 21st century, the program faces unprecedented challenges. The number of elderly is growing, and their life expectancy is lengthening. The traditional Medicare benefit package, reflective of average indemnity plans in 1965, is not as generous as most employer sponsored plans. Gaps in coverage contribute to high out-of-pocket spending relative to income for many seniors. In addition, advances in medical practice and technology are requiring Medicare to modernize its benefits package. New ways of delivering benefits also are challenging Medicare to find new, cost-effective ways to deliver health care. Medicare’s challenges are clear.
**Increasing the Beneficiary Population**

As the baby boom ages, the number of Medicare beneficiaries will double to 80 million. By 2035, 22 percent of the population will be covered under Medicare, up from 14 percent today. However, the ratio of workers who support Medicare beneficiaries is expected to decline by over 40 percent by 2030, from 3.6 workers per beneficiary in 2010 to 2.3 in 2030.\(^8\)

![Medicare Enrollment Graph](image)

**Outdated Benefits Package**

Medicare has not fully kept pace with developments in health care treatment. Prescription drugs have become central to modern medicine, but the program has no prescription drug benefit. As a result, millions of seniors find themselves faced with the dilemma of trying to pay for the prescriptions they need and pay for life’s necessities. Similarly, primary care services such as screenings for glaucoma, hearing and vision impairment, and hypertension are not currently included in the Medicare benefit package, causing many beneficiaries with these conditions skip treatment until they are in need of urgent care.
**Increasing Costs**

In the early 1990’s, Medicare spending growth outpaced private health insurance growth. Today, as a result of the success of the Clinton-Gore Administration’s efforts to constrain cost growth, Medicare is actually growing at a rate that is substantially below that of the private sector. However, independent Medicare actuaries are projecting that cost will increase in the out-years at the same time that the total number of beneficiaries in the program significantly escalates.

**Outdated and Inefficient Payment Systems**

Despite improvements under the Clinton-Gore Administration, Medicare remains governed by statutory constraints that limit its ability to adopt innovative payment and management strategies that reduce costs and increase quality. By paying a flat rate, set by a complex statutory formula that has nothing to do with plan prices, Medicare has been unable to harness competition to pay managed care plans accurately. Moreover, the fee-for-service traditional program has not been given the purchasing tools that the private sector has successfully used to improve efficiency and make the program more competitive. Clearly, Medicare payments for managed care and the traditional program needs to be modernized and made more competitive.

**Medicare’s Current Surplus at Risk**

Today, the Medicare Trust Fund, which is financed mostly by workers’ payroll taxes, has a surplus. However, unless that surplus is protected, it may well be tapped for other uses. This would not only puts Medicare at risk of being unable to face its future obligations, but would also contribute to a higher national debt since this surplus would not be used to reduce that debt.

**IV. CONCLUSION**

In the 35 years since its creation, Medicare has largely fulfilled its promise, providing health insurance to generations of older Americans and Americans with disabilities. It has helped keep millions out of poverty and ensure that all Americans have the opportunity to lead better, healthier, more prosperous lives. Today, however, Medicare faces significant challenges. How we respond to these challenges will reflect what kind of nation we are: one that takes care of its most vulnerable, or one that fails to live up to our profound responsibility to them.
CHAPTER 2
PROTECTING MEDICARE

The long-term solvency of Medicare is the first and foremost priority of Al Gore and Joe Lieberman’s approach to strengthening Medicare. That is why they have proposed a three-step plan to protect Medicare and extend its life. First, they will place Medicare in an iron-clad, off-budget lockbox that would prevent politicians from using Medicare as a piggy bank to pay for unnecessary tax cuts or spending increases. Second, they will use any surplus in Medicare to pay down the debt. Third, Al Gore and Joe Lieberman want to go one step further and use the benefits of this lockbox to add resources to Medicare, helping to extend its life to at least 2030. Al Gore feels so strongly about this that he pledges that as President, he will veto the use of any money from Medicare for anything other than Medicare.

In contrast, George W. Bush and Dick Cheney have rejected the Medicare lockbox. They have released a budget that does not contain a single line to protect the Medicare lockbox. As Paul Krugman, the Massachusetts Institute of Technology economist, wrote: “Congressional Republicans have solemnly pledged to put both Social Security and Medicare in ‘lockboxes,’ that is, not to count their surpluses as available funds. But while Mr. Bush’s number-crunchers ostentatiously put the Social Security surplus aside, Medicare somehow goes unmentioned.” Instead, the Bush-Cheney plan uses the majority of the Medicare surplus — which is generated by payroll contributions of millions of workers — to pay for an expensive tax giveaway that mainly benefits the wealthy.

In the end, George W. Bush and Dick Cheney do not devote a single dime to extend the solvency of Medicare. To match the contribution of the Gore-Lieberman lockbox to solvency would require the Bush-Cheney plan to raise payroll taxes, make large hikes in premiums, or substantial reductions in Medicare benefits.
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<th>Gore-Lieberman Plan</th>
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<td>Medicare Lockbox to Protect</td>
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<td>Payroll Taxes for Medicare</td>
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<td>Pay for Tax Cuts</td>
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<tr>
<td>Pay for Tax Cuts For the Top 1%</td>
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<td>Added to Medicare’s Solvency</td>
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I. THE GORE-LIEBERMAN PLAN TO PROTECT AND STRENGTHEN MEDICARE

Al Gore and Joe Lieberman have a simple, common sense three step plan to protect Medicare and extend its life:

Step 1: Protect Medicare payroll tax money for Medicare only. Al Gore and Joe Lieberman believe that when people pay Medicare payroll taxes today, these taxes should only be used for Medicare – to pay benefits today and to ensure that Medicare is there for them tomorrow. That is why a Gore-Lieberman Administration will establish a lockbox to keep Medicare safe, and veto the use of any money for Medicare for anything other than Medicare.

Step 2: Protect Medicare surpluses for debt reduction. If we take in more in payroll taxes than we pay out in Medicare benefits, we should save the additional payroll taxes to prepare for the future of Medicare. We can effectively save these payroll taxes by using them to pay down our debt.

Step 3: Use the interest savings from debt reduction as part of a plan to extend the life of Medicare to at least 2030. Paying down the debt will cut down – and eventually eliminate – interest payments. Al Gore and Joe Lieberman will use the money we save to help extend the life of Medicare to at least 2030.
Step 1: Protect Medicare Payroll Taxes for Medicare Only

Al Gore and Joe Lieberman believe that Medicare represents a solemn commitment. Every year workers contribute payroll taxes to Medicare – the combined employee-employer contribution is 2.9 percent of earnings, or $136 billion this year. These payroll contributions are used to pay Medicare benefits today and to ensure that Medicare can continue to pay benefits in the future.

Medicare is currently enjoying favorable times, with payroll taxes and other income exceeding benefit payments. These surpluses have grown from $4 billion in 1993 to a record $25 billion in 2000. Over the next decade, these surpluses are projected to grow still further, totaling $360 billion. With these growing surpluses comes a growing temptation to use Medicare as a piggy bank to pay for tax cuts or spending increases. Al Gore and Joe Lieberman’s plan will prevent that by creating a Medicare lockbox, without trapdoors and with protections for Medicare solvency.

Step 2: Protect Medicare Surpluses for Debt Reduction

The second step of the Gore-Lieberman plan is that if Medicare is running surpluses today, we should save those surpluses for the future. We can effectively save these payroll taxes by using them to pay down our debt. This will improve the financial position of the government, ensuring that we will be able to meet our commitments to Medicare when they come due. In fact, devoting the currently projected Medicare surpluses to debt reduction will pay down the debt by $360 billion over 10 years.

As an added protection, Al Gore and Joe Lieberman will also establish a new $300 billion Surplus Reserve Fund. This will explicitly “underspend” the surplus. This fund will act as a cushion against unforeseen events whether they be major natural disasters, military conflicts, or weaker economic growth. With this fund in place, if unexpected costs materialize, we will not be forced to decide between raiding Medicare or cutting spending and increasing taxes.

Step 3: Use the Interest Savings from Debt Reduction to Extend the Life of Medicare to at least 2030

Devoting the Medicare surplus to debt reduction produces interest savings. In turn, Al Gore and Joe Lieberman will dedicate these interest savings to the Medicare trust fund, as part of their overall plan make Medicare solvent to at least
2030. Over the next decade, these interest savings are projected to total $75 billion, and continue to grow thereafter.

This may seem complicated, but it is no different than a family with a huge credit card debt deciding they want to save more for their children’s education. Suppose the family is currently paying $1,000 a year in interest on their credit card debt. If they pay down that debt, it will be just like having an extra $1,000 a year to spend. By saving more now, they can be in a stronger position tomorrow.

But there is also another step. Instead of taking these added resources and using them to help pay for an expensive vacation, they can commit to using their savings to help pay for their children’s education in the future. This simple example illustrates what Al Gore and Joe Lieberman want to do with our national debt: pay it down and invest the savings to keep Medicare strong.

II. THE BUSH-CHENEY PLAN RAIDS MEDICARE AND DOES NOT ADD A PENNY TO ITS SOLVENCY

George W. Bush and Dick Cheney do not dedicate one dime to keep Medicare solvent. They do have a budgetary lockbox, leaving Medicare susceptible to raiding by politicians. Instead, they support a large tax cut for the wealthiest Americans and spending plans that would force a Bush-Cheney Administration to raid Medicare.

Bush-Cheney: Raiding Medicare, Breaking Even with Their Own Party

Overwhelming bipartisan majorities in the House and Senate have followed Al Gore’s call and voted for Medicare lockboxes that endorse the principle that Medicare surpluses should be devoted to paying down the debt. House Speaker Dennis Hastert himself wrote that he has “agreed to devote the entire Social Security and Medicare surpluses to debt reduction.” Al Gore and Joe Lieberman support an even stronger lockbox that would truly take Medicare off-budget, without loopholes or trapdoors.

But George W. Bush and Dick Cheney have not endorsed a Medicare lockbox. They do not have a single line in their budget indicating support for any of the three steps of the Gore-Lieberman plan. They have not pledged that Medicare payroll taxes should be protected to fund Medicare benefits today and in the future. They have not pledged to use any Medicare surpluses to pay down the debt to
prepare for our future obligations. And they have not pledged to use any interest savings from devoting Medicare surpluses to debt reduction to extending the life of Medicare.

Moreover, their tax cut and spending plans would make it impossible for them to support any of these pledges. George W. Bush has proposed a tax cut that, with interest, would cost $1.6 trillion – using up almost the entire non-Social Security, non-Medicare surplus. He has proposed spending plans that with interest would cost another nearly $600 billion. As a result, he is forced to use the Medicare surplus to pay for his plans.

Instead of using the Medicare surpluses to prepare for the future of Medicare, the Bush-Cheney plan uses the majority of the surplus to pay for a tax cut, most of which goes to the wealthiest Americans. The following shows, by their own numbers, how the Bush-Cheney campaign uses the projected $360 billion Medicare surplus from 2001-10:

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<thead>
<tr>
<th>BUSH-CHENEY USE OF THE MEDICARE SURPLUS</th>
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<tr>
<td>Spending Increases ($582 billion)</td>
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<td>Tax Cuts ($1.6 trillion)</td>
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<td><em>Tax Cuts for top 1% ($666 billion)</em></td>
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In fact, the Medicare lockbox passed by the House would prevent the President from submitting a budget to Congress if it uses any of the Medicare surplus for other spending without saving Medicare. Under this clause, if Governor Bush ever became President Bush, he could not legally transmit the budget featured on his website to the United States Congress.

What the Bush-Cheney Plan Means for Medicare

George W. Bush and Dick Cheney do not invest a single penny to extend the life of Medicare. Furthermore, by taking Americans’ Medicare payroll contributions and using them to pay for tax cuts for the wealthiest, George W. Bush and Dick Cheney will make it impossible to meet our commitments to the future.

By devoting Medicare surpluses to debt reduction, the Gore-Lieberman plan produces interest savings of $75 billion over 10 years and continuing thereafter. By
devoting these interest savings to Medicare, they extend its life past 2030. In 2010 alone, these interest savings are $18 billion.

Because the Bush-Cheney plan does not have a Medicare lockbox, they would be forced to make painful and unnecessary choices to save $18 billion for Medicare in that year. There are three ways that Medicare revenues could be raised by $18 billion in that year or Medicare benefits reduced by $18 billion in that year:

1. They could increase premiums by $32 per month ($384 per year). This would be a 35 percent increase in the projected premium for 2010. With a projected Medicare enrollment of 47 million people in 2010, this would raise $18 billion.5

2. They could entirely eliminate Disproportionate Share Hospitals (DSH), General Medical Education (GME), Indirect Medical Education (IME), and Hospices, which together are projected to cost $18.4 billion in 2010.6

3. They could increase Medicare payroll taxes for all workers by 8 percent.

III. CONCLUSION

Today, we are enjoying a moment of historic prosperity. Medicare is as healthy as it has ever been. It is running substantial surpluses. But Medicare still needs help, and America faces a major choice about what to do about it. We could squander this opportunity to strengthen Medicare by consuming all of our resources – and more – over the next years with a tax giveaway to the wealthiest Americans. While this tax cut might be politically appealing to some groups, the result would be that when the bills come due, we will face painful choices about benefit cuts or tax increases.

Al Gore and Joe Lieberman look at the Bush-Cheney plan and believe that there is another, more responsible way. They believe that we make the right choices today, we can avoid painful choices tomorrow.

The Gore-Lieberman is based on the premise that we can act prudently today to help prepare ourselves to meet our commitments to the future. Al Gore and Joe Lieberman will protect the money coming in to Medicare by putting Medicare into an ironclad lockbox where no politician can raid it. They will use Medicare’s surplus to pay down the debt, and use these savings to extend the life of Medicare itself. By
taking these steps, Al Gore and Joe Lieberman honor the American values that led to Medicare’s creation more than three decades ago.
CHAPTER 3
IMPROVING MEDICARE

The pace of medical progress is truly amazing. Every week, it seems that a new discovery offers new hope. For 35 years, Medicare has provided quality care for millions of seniors. However today’s Medicare is not fully prepared to offer the range of coverage necessary to give seniors high-quality medical care.

At a time when prescription drugs are at the forefront of modern medicine, Al Gore and Joe Lieberman believe Medicare needs to treat prescription drugs as a medical necessity, not an optional luxury. At a time when preventative care can delay, diminish, and often block the onset of disease, Al Gore and Joe Lieberman believe we need to dramatically expand access to prevention.

Today, Medicare’s benefit package more closely resembles the typical health plan from 1965, rather than the typical plan for the year 2000. In fact, the value of Medicare’s benefit package is 20 percent lower than the value of most private insurance plans. Medicare also fails to cover key benefits that are especially important to seniors and people with disabilities: prescription drugs and a full range of preventative benefits.

At this time of remarkable progress, Al Gore and Joe Lieberman believe Medicare needs to ensure that promise of American medicine is translated into improvements in the health of America’s seniors.

I. IMPROVING MEDICARE BY ADDING A PRESCRIPTION DRUG BENEFIT

When Medicare was created, prescription drugs were not considered an essential part of American health care. Today, prescription drugs are at the core of medical treatment. They do more than ever before to sustain life and health – especially for seniors and people with disabilities.

And yet, today, in any given year, nearly half of all Medicare beneficiaries go without prescription drug coverage. Millions more have inadequate, unreliable and expensive prescription drug coverage through private “Medigap” insurance or Medicare managed care plans. Hardly any of these plans cover catastrophic drug costs.
Older Americans and people with disabilities who lack prescription drug coverage typically pay 15 percent more for prescription drugs than insurers who can negotiate price discounts. As a result, uncovered Medicare beneficiaries purchase one-third fewer drugs but pay nearly twice as much out of pocket.

In this time of great prosperity, it is unacceptable that so many seniors and people with disabilities have to choose between medicine and food and rent. It is unacceptable that so many seniors have to cut their dosage – gambling with their health to save pills and dollars.

Al Gore and Joe Lieberman will improve Medicare by adding prescription drug benefit that would cover all seniors and people with disabilities under Medicare. Their prescription drug benefit will be both affordable and voluntary.

**Prescription Drug Coverage is Good Medicine**

Prescription drugs today serve as complements to medical procedures, substitutes for medical procedures, and treatments that provide new hope for recovery where there once was none.

For example, anti-coagulants are used to increase the effectiveness of heart valve replacement surgery. Lipid lowering drugs can reduce the need for bypass surgery. And medications used to manage Parkinson’s disease offer new hope for longer, healthier lives. As our understanding of genetics grows, the possibility for breakthrough pharmaceuticals will increase exponentially.

For many seniors on Medicare, prescription drugs offer safer, more cost-effective treatment than invasive procedures or therapies that put them at greater risk for infection or other complications. For example, one study found when seniors have only limited prescription drug coverage, that doubles the risk of their entering a nursing home – where average costs exceed $50,000 per year.¹

Not only do the elderly and people with disabilities have more problems with their health, but these problems tend to include conditions that respond to drug therapy. The elderly are responsible for about one-third of all drug spending, despite the fact the they represent about 12 percent of the population. Not surprisingly, about 85 percent of beneficiaries fill at least one prescription a year for such conditions as osteoporosis, hypertension, myocardial infarction (heart attacks), diabetes, and depression.
Recent research has determined that being uninsured leads to significant declines in the use of necessary medications. This, in turn, has also been found to double the likelihood that low-income beneficiaries enter nursing homes. One study concluded that drug-related hospitalization accounted for 6.4 percent of all admissions of the over 65 population and estimated that over three-fourths of these admissions could have been avoided with proper use of necessary medications.2

**Millions of Medicare Beneficiaries Lack Dependable Prescription Drug Coverage**

Prescription drugs have never been more important, but the people who rely on them most – the elderly and people with disabilities – increasingly find themselves either uninsured or with coverage that is becoming more expensive and less meaningful. Getting affordable, essential prescription drugs is not only a problem for the millions of Medicare beneficiaries without any insurance – it is increasingly a challenge for beneficiaries who do have coverage.

*At least 13 million Medicare beneficiaries have absolutely no prescription drug coverage and three out of five lack decent, dependable coverage.*

For the three-fifths of Medicare beneficiaries who neither have retiree health insurance nor qualify for Medicaid, there are only two options for prescription drug coverage: purchase private Medigap insurance or join a Medicare managed care plan. Medigap insurance is not only expensive but only covers up to $1,250 or $3,000 of prescription drug costs, depending on the plan. Similarly, Medicare managed care coverage is limited, inaccessible to most rural beneficiaries and unreliable for those who have the option (see description below). As a result, over 13 million beneficiaries have no coverage for prescription drugs throughout the year, and nearly half lack coverage for part of the year. This is projected to rise; the Congressional Budget Office projects that 16 million Medicare beneficiaries will lack drug coverage throughout the year by 2003.3

*More than half of Medicare beneficiaries without drug coverage are middle class*

The number of the Medicare beneficiaries who do not have prescription drug coverage is not concentrated among those with low income. In fact, the income distribution of uninsured Medicare beneficiaries is almost exactly the same for beneficiaries at all income levels. About half of Medicare beneficiaries without drug coverage have incomes in excess of 175 percent of poverty – an annual income of
approximately $14,600 for a single person. This clearly indicates that any prescription drug coverage plan that limits coverage to below 175 percent of poverty, as the Bush plan initially does, will leave the vast majority of the Medicare population unprotected.

**MANY UNINSURED IN MIDDLE CLASS**

*About Half of Medicare Beneficiaries Who Lack Prescription Drug Coverage Are In The Middle Class*

**Income of Beneficiaries Without Prescription Drug Coverage**

(As A Percent Of Poverty)

- Less Than 100% Poverty: 24%
- 100% to 175% of Poverty: 27%
- Greater Than 175% of Poverty: 49%

SOURCE: Actuarial Research Corporation for HHS, 2000. In 2000, poverty for a single person is about $8,500, for a couple is about $11,400.

The Need For a Voluntary Prescription Drug Benefit Option Under Medicare

Despite the indisputable importance of prescription drugs to health care today, Medicare does not explicitly cover medications. The current nature of the private insurance market today reinforces the need for a minimum drug benefit option for all Medicare beneficiaries.

**Declining and unstable coverage through Medicare managed care**

About 17 percent of Medicare beneficiaries have coverage through Medicare managed care, which is a declining and unstable source of coverage. Many beneficiaries are losing coverage as HMOs pull out of Medicare. Almost one million Medicare beneficiaries will lose coverage next year because these managed care plans
are pulling out. Other plans are reducing coverage and increasing premiums. In the year 2000, nearly three-fifths of managed care plans reported that they were going to cap their benefits at $1,000 per year. And the proportion of plans with $500 caps or lower benefit caps increased by 50 percent between 1998 and 2000.

**Fewer companies offering retiree health coverage**

The proportion of firms offering retiree health coverage has declined by 25 percent in the last four years. Retiree health coverage is declining substantially because many firms previously providing it are dropping their coverage. The decline was more pronounced among the largest employers (greater than 5,000 employees), over a third of whom dropped coverage in this period.

**Medigap premiums for drugs are high**

Medigap premiums vary widely throughout the nation but are consistently two to three times higher than the Medicare premium proposed by Gore-Lieberman. The average Medigap plan including drug coverage costs $135 per month ($1,620 per year), but exceeds $150 per month in nine states.

The part of the premium that is attributable to drugs alone can be $90 per month or $1,080 per year for coverage that is limited to $1,250 per year with a $250 deductible. Finally, even those who do have Medigap coverage end up paying
significant out-of-pocket costs, $650 per month on average. For these reasons, only about 8 percent of beneficiaries purchase Medigap coverage for prescription drugs.

**Medigap premiums substantially increase with age**

Medigap premiums are substantially higher for older beneficiaries since most states allow Medigap plans to “age rate” the cost of the premium. This means that just as beneficiaries need prescription drug coverage most and are the least likely to be able to afford it, this drug coverage is being priced out of reach – on average, an 80 year old is charged premiums that are 33 percent higher than that of a 65 year old, and in some states, even more. This cost burden will particularly effect women, who make up 73 percent of people over age 85.

**The limits of plans targeted only to low-income seniors**

Fewer than half of the low-income Medicare beneficiaries would likely get drug coverage through a program limited to low-income seniors. Fifty-five percent of low-income Medicare beneficiaries currently do not enroll in Medicaid even though they are eligible. In addition, fewer than 800,000 seniors are enrolled in state pharmacy assistance programs. These state-initiated programs have low participation rates and, in 8 or the 14 states with such programs, more than 90
percent of Medicare beneficiaries are excluded. In contrast, 98 percent of eligible people nationwide enroll in Medicare.

**Adding a Prescription Drug Benefit for All Seniors Under Medicare**

Because outpatient prescription drugs are not covered by Medicare, nearly half of beneficiaries go without coverage for all or part of the year⁵ – about the same percent as lacked hospital insurance when Medicare was created in 1965. Older Americans and people with disabilities without drug coverage typically pay 15 percent more than insurers who negotiate price discounts for the same prescription drug. As a result, uncovered Medicare beneficiaries purchase one-third fewer drugs but pay nearly twice as much out-of-pocket.⁶

The situation is even worse for rural Medicare beneficiaries, who are over 60 percent more likely to fail to get needed prescription drugs due to high cost.⁷ Medicare beneficiaries with disabilities face unique challenges, being less likely to have private coverage but needing more and different types of prescriptions than the elderly.⁸ Because people with disabilities need the drug benefits under Medicaid, the absence of prescription drug coverage is another barrier to returning to work.

To address this extraordinary challenge, Al Gore and Joe Lieberman will establish a new voluntary Medicare prescription drug benefit that is affordable both to the program and to all of its beneficiaries. The drug benefit, which costs $253 billion over 10 years on the OMB baseline and $338 billion on the CBO baseline, is designed to be affordable, accessible, meaningful, and competitively administered.

One of the central features of the Gore-Lieberman prescription drug benefit is that it is accessible and voluntary for all Medicare beneficiaries. This Medicare prescription drug benefit option would be integrated into beneficiaries’ health plan choices, so that eligible seniors could choose to get their prescriptions through the traditional program, managed care, or a retiree plan if available. Those who currently have employer-based coverage could keep that coverage.

For the first time in program history, Medicare managed care plans would receive direct payments for the provision of a prescription drug benefit. This should stabilize the Medicare managed care market and contribute towards making it more competitive. Enrollment would occur in the first year of the program, when a person becomes eligible for Medicare and at other, selected points. All participants would be guaranteed, in return for their premium, reliable, affordable coverage.
How would this benefit work:

- **Shared costs.** The costs of this benefit would be shared between participants and the program. Voluntary premiums would begin at $25 per month in 2002, and would be lower or nonexistent for low-income beneficiaries (no premium below 135 percent of poverty; sliding scale premium between 135 and 150 percent of poverty). Premiums for participants would be paid just like the current Part B premium.

- **No deductible.** By paying this premium, enrollees would receive a benefit that has no deductible and pays for half of total costs from the first prescription filled up to $5,000 in spending when fully phased in.

- **Catastrophic coverage.** Beneficiaries with catastrophic spending on prescription drugs would be protected through a $4,000 limit on out-of-pocket spending beginning in 2002. Low-income beneficiaries (those with incomes below 135 percent of poverty) would pay no cost sharing.

- **Negotiated discounts.** All participants would benefit from privately negotiated discounts, gained by pooling beneficiaries’ purchasing power for all drug expenses. This discount would be at least 10 percent off the total cost of drugs, perhaps explaining why the big drug companies have fought this plan.

- **Consistent administration.** Prescription drug coverage would be administered for enrollees in managed care and retiree health plans in the same way that it is today – except that Medicare would now contribute towards drug costs. For traditional Medicare enrollees, Medicare would adopt the approach used by the best employers, health insurers, and managed care plans in the private sector today.

- **Pharmaceutical benefit managers.** It would create numerous public-private partnerships with pharmaceutical benefit managers (PBMs) that now manage prescriptions for more than 200 million Americans. Medicare would competitively contract out with PBMs in multiple regions across the country.

As is the case in the private sector today, PBMs would not bear the risk of providing prescription drugs (i.e., they would not be insurers). The private managers would use the latest, effective cost containment tools, drug utilization review programs, and meet quality and consumer access standards.
This partnership would both provide beneficiaries with the same high-quality benefits that they expect from Medicare while allowing for more flexibility and innovation in program management over time. No price controls would be used, and are statutorily prohibited.

Regardless of their plan choice, all Medicare beneficiaries enrolled in the prescription drug option would have access to all medically necessary prescriptions, even if not on the plan’s formulary. In addition, the benefit managers would compete on and be required to use of state-of-the-art quality improvement tools. Finally, benefit managers would have to contract with qualified pharmacists since access to local community pharmacists is particularly important to the elderly.

To encourage employers to offer or continue retiree drug coverage, direct subsidies would be provided to help offset employers’ premium costs. Specifically, Medicare would contribute 67 percent of its premium subsidy for the Medicare benefit, less than what it would pay if the beneficiary enrolled in Medicare but more than what the employer receives today. Retirees would not have to do anything to keep their current coverage. Employers would apply for the incentive program. After providing assurance that their drug benefit is at least as good as the Medicare benefit, employers could get the assistance directly or have it sent to their health insurer. Retirees in employer plans that drop coverage or reduce it below the value of Medicare’s benefit would have a special opportunity to enroll in the Medicare drug benefit. This creates a win-win situation for employers and retirees, and saves the program money.

**Key Points of the Gore-Lieberman Prescription Drug Plan**

- Ensures all Medicare beneficiaries access to a voluntary prescription drug benefit – whether they choose traditional Medicare or managed care;

- Ensures that all beneficiaries have their choice of doctor and guarantees they can get the prescriptions their doctor recommends at the pharmacy of their choice;

- Covers half of the costs of all prescriptions from the first trip to the pharmacy up to $5,000 per year; ensures discounts for all spending.

- Provides catastrophic protections to ensure that no senior or person with disability ever pays more than $4,000 per year for prescriptions;

- Ensures that the lowest-income beneficiaries pay no premiums or cost-sharing.
II. ALLOWING VULNERABLE 55 TO 65 YEAR OLDS TO BUY INTO MEDICARE

Al Gore and Joe Lieberman believe that many Americans between the ages 55 to 65 — the fastest growing group of uninsured in the country, and some of the most vulnerable to the vagaries of the private market — should be able to buy into Medicare to get the health coverage they need.

Twenty-two percent of Americans aged 55 to 65 — a total of five million people — are either uninsured or insured through the individual insurance market. In some states, such as North Dakota, Texas, and Nebraska, the percentage is over 30 percent. Three million people in this age group are uninsured.

Some Americans in this age bracket lose their employer-based health insurance when their spouse becomes eligible for Medicare. Many lose their coverage because they lose their jobs in company downsizing or plant closings. Still others lose insurance when their retiree health coverage is dropped unexpectedly.

Whatever the reason, the coverage is lost and many are left to buy into an unaffordable individual insurance market, where premiums can be as high as $1,000 per month. Individual insurance can be prohibitively expensive, particularly for those who have pre-existing medical conditions. In 38 states, individual insurance policies can be denied outright. Sixteen million Americans ages 55 to 65 — three-quarters of this population — live in one of the 38 states where individual insurance has no guarantee issue requirement. These individuals often have nowhere to turn for health care coverage.

In 21 states, there are no assurances that pre-existing conditions are adequately covered. Eight million Americans ages 55 to 65 — more than one-third of this population — live in states that allow individual insurers to decline to cover pre-existing conditions. This means that individuals may not be able to get coverage for the care they need most, such as diabetes maintenance or cancer treatment. In 34 states, there are no protections against exorbitant premiums. Sixteen million Americans ages 55 to 65 — three-quarters of this population — live in states that do not protect individuals against exorbitant premiums.

The Gore-Lieberman Plan

Al Gore and Joe Lieberman have a plan to allow this vulnerable population to buy into the Medicare program — giving them an affordable quality health
insurance policy. They will enable Americans ages 62 to 65 to buy into Medicare by paying a premium. They will provide displaced workers over 55 access to Medicare by offering those who have involuntarily lost their jobs and their health care coverage a similar Medicare buy-in option. This is particularly necessary, because these workers often have a hard time finding new jobs: only 52 percent are reemployed, compared to over 70 percent of younger workers. These workers would qualify for a 25 percent tax credit to make the premium even more affordable.

The Gore-Lieberman plan also allows retirees ages 55 and older, whose employers dropped their health coverage, gain access to their former employers’ health plan. They will be able to buy into their employers’ health plans through “COBRA” coverage. The Congressional Budget Office estimated that the premium for the Medicare buy-in would be $326 per month in 2002. With the Gore-Lieberman 25 percent tax credit, it would be $245, making it affordable enough to help 650,000 in the first year of the plan and 1.3 million people by 2010. Moreover, there appears to be a great demand for such coverage: according to a recent survey, nearly two-thirds (63 percent) of people ages 50 to 64 would be interested in getting Medicare before turning 65.
WHAT THE GORE-LIEBERMAN MEDICARE BUY-IN PLAN WOULD MEAN FOR REAL PEOPLE

A 62-year old woman with hypertension, who has been a foster mother and community volunteer for 25 years, has lost her health insurance because her husband retired. This couple has a combined income of $45,000. Under current law, she would have no choice but to purchase an expensive individual health insurance plan, costing $7,147. Under the Gore-Lieberman plan she will be able to buy into Medicare, saving her substantially on premiums. In addition, she can use the Gore-Lieberman health tax credit to cut her premiums by another 25 percent. Under the Bush-Cheney plan she would still have no choice other than to buy the expensive individual plan, and she will only get a $500 tax credit to help defray the costs. As a result, the Gore-Lieberman plan provides 8 times more savings as the Bush-Cheney plan.

<table>
<thead>
<tr>
<th>Current Law</th>
<th>Gore-Lieberman</th>
<th>Bush-Cheney</th>
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</thead>
<tbody>
<tr>
<td>Full Cost of Coverage</td>
<td>$596 / month</td>
<td>$326 / month</td>
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<td></td>
<td>$7,147 / year</td>
<td>$3,912 / year</td>
</tr>
<tr>
<td>Savings on Premiums through Medicare Buy-in</td>
<td>$0</td>
<td>$270 / month</td>
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<tr>
<td></td>
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<td>$3,235 / yr</td>
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<tr>
<td>Health Insurance Tax Credit</td>
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<td>$978 tax credit</td>
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<tr>
<td>What Person Pays</td>
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<td>$245 / month</td>
</tr>
<tr>
<td></td>
<td>$7,147 / year</td>
<td>$2,934 / year</td>
</tr>
<tr>
<td>TOTAL SAVINGS</td>
<td>-$4,213</td>
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III. PROMOTING HEALTHY AGING: THE GORE-LIEBERMAN PLAN TO MAKE PREVENTATIVE BENEFITS MORE ACCESSIBLE

As medical science discovers new ways to manage serious diseases in their early stages, it is more important than ever that the Medicare benefit package be expanded to include early detection and prevention services. Older Americans are the fastest growing age group in the United States and carry the highest rates of chronic disease and disability, much of it preventable. Eighty-eight percent of those
over the age of 65 have at least one chronic health condition, and large numbers of older adults suffer from impaired functioning and well being. However, early detection, health screening programs, and appropriate follow-up care can result in a significant reduction in morbidity and possibly prevent or postpone functional disability.

**Preventative Services**

As a member of Congress, Al Gore cosponsored legislation to examine preventative health care programs for the elderly and to fund primary pediatric care for disadvantaged children. In the Balanced Budget Act of 1997, the Clinton-Gore Administration waived cost-sharing for mammography services and provided annual screening mammograms for beneficiaries age 40 and older to help detect breast cancer; established a diabetes self-management benefit; ensured Medicare coverage of colorectal screening and cervical cancer screening; ensured coverage of bone mass measurement tests to help women detect osteoporosis, and increased reimbursement rates for certain immunizations to protect seniors from pneumonia, influenza, and hepatitis.

However, according to recent studies, Medicare preventative services are underutilized. For example, in 1995-96, only one in four women in their sixties were tested as often as recommended for breast cancer. In the first two years that Medicare covered screening mammographies, only 14 percent of eligible women without supplemental insurance received a mammogram. In addition, although only two percent of Medicare beneficiaries received flexible sigmoidoscopy to screen for colon cancer, despite national guidelines recommending regular screenings.

Part of the reason for this lack of participation may be financial. Gaps in benefits coverage and Medicare’s current requirement of a $100 deductible and a 20 percent copayment for Part B benefits exposes many Medicare beneficiaries to the financial burden of medical bills, including for preventative care. Recent studies report that one out of seven Medicare beneficiaries have problems paying their medical bills.

In order to eliminate financial barriers to critical preventative services, the Gore-Lieberman plan eliminates the Part B deductible and 20 percent coinsurance rate for all Medicare preventative services, in both the managed care and fee-for-service programs, ensuring that beneficiaries will never have to pay out of pocket to access critical preventative screenings. The deductible will be eliminated for hepatitis B vaccinations, colorectal cancer screening, bone mass measurements,
prostate cancer screening, and diabetes self management benefits. Copayments will be eliminated for screening mammographies, pelvic exams, hepatitis B vaccinations, colorectal cancer screening, bone mass measurements, prostate cancer screenings, and diabetes self-management benefits.

<table>
<thead>
<tr>
<th>COST SHARING REQUIREMENTS FOR PREVENTATIVE SERVICES</th>
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<tr>
<td>THE GORE-LIEBERMAN PLAN</td>
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<table>
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<tr>
<th>BENEFIT</th>
<th>CURRENT LAW</th>
<th>GORE-LIEBERMAN</th>
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<tr>
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<td>Screening Mammography</td>
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<td>Prostate Cancer</td>
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</table>

New Fast-Track Coverage of New Preventative Benefits

Currently, enhancing the Medicare benefit package to include a new preventative screening service is a difficult and slow process. It requires a legislative change, making it extremely difficult to provide beneficiaries with timely access to preventative services that have proven effective for the Medicare population. For example, although the medical community has long recognized that the regular use of prevention and monitoring services can help minimize the complications associated with diabetes, Medicare did not cover this benefit until 1998.

In order to ensure that Medicare beneficiaries are receiving health care services reflecting standards set by the medical community, the program needs to be
flexible enough to respond quickly to the latest biomedical and health services research.

In order to address this concern, the Al Gore and Joe Lieberman will modernize Medicare by creating a new “fast track” Medicare coverage proposal that has an expedited approval process for cutting edge disease prevention and screening benefits.

Under this proposal, the Department of Health and Human Services would establish a board of independent medical experts to evaluate the medical efficacy and cost-effectiveness of new clinical preventative services, screening tests, and immunizations on an age-and risk-factor-specific basis. Services would have to be projected to be cost-effective over a period of 10 years. Based upon the recommendation of these independent experts, the Administration would submit a notice of intent to expand Medicare to cover a new preventative service to the Congress. If Congress did not act to halt HHS’s proposed action within 90 days, the benefit would automatically be included in the Medicare program.

In order to facilitate this process, the United States Preventative Services Task Force, together with the Centers for Disease Control, would be charged with identifying a range of clinical preventative services, including common screening tests, immunizations, and counseling for health behavior change, for the review of the independent committee. These would focus primarily on preventative interventions that can be delivered in the primary care setting, are widely available, and for which scientific evidence exists to assess efficacy and effectiveness.

**Modernizing Preventative Benefits Currently Included In Medicare**

Currently, the frequency with which Medicare beneficiaries can receive preventative services, such as colon cancer screenings, is established in statute. This makes it extremely difficult for the benefit package to change to match the most recent recommendations on type of screening device and screening frequency established by the medical community. For example, despite the fact that many medical experts recommend annual colonoscopies for individuals at high risk of developing colon cancer, Medicare limits coverage of this type of screening for these individuals to once every two years. In addition, although many medical experts recommend annual Pap smears for all women over the age of 18 – even those past menopause – Medicare only provides this test once every three years unless a woman is identified as being of high risk.
Al Gore and Joe Lieberman will eliminate any screening guidelines established in statute and instead instruct Medicare to provide screenings with the frequency and using the type of device recommended by a panel of independent medical experts. This proposal ensures that Medicare can respond quickly to advances in medical research and provide consistently high quality care to beneficiaries.

**Primary Care Case Management and Disease Management**

Private health insurance plans are increasingly choosing to coordinate a range of health services to ensure that high-risk, high-cost beneficiaries use the preventative and primary care services they need to prevent the onset of severe and costly illnesses. Studies indicate that regular interaction with primary care providers help identify health problems in elderly people previously unknown to their regular health care provider. In addition, studies have found that intensive case management services increase the use of preventative services and reduce the use of emergency room and other ancillary services. This care management is especially important for older and sicker beneficiaries, who may have a diminished capacity to navigate the health care system.

Since a small fraction (5 percent) of beneficiaries account for 45 percent of Medicare spending, this is provides good fiscal management as well as high-quality care. Private sector disease management vendors indicate they are achieving savings of 20 to 50 percent for selected high-cost, chronic diseases.

Al Gore and Joe Lieberman will give the Medicare program the authority to contract with primary care physicians to coordinate the full range of health care services used by high-risk or chronically ill beneficiaries in areas where there is evidence of poor coordination of care or inappropriate utilization of services, such as a high rate of hospitalization for conditions that could be treated in outpatient settings. In addition, they will provide Medicare with the authority to provide targeted disease management services, such as patient screening and assessment, review of medications, patient education, telephone consultation, and home nursing visits for individuals diagnosed with a high-risk health condition, such as congestive heart failure and diabetes. These proposals will ensure that these vulnerable beneficiaries can easily access the full range of health services they need.

**IV. CONCLUSION**

Since 1965, Medicare has guaranteed health care for our nation’s seniors. But it has not kept up with the advances in health care since its inception. Today,
Medicare’s benefit package more closely resembles the typical health plan from 1965 rather than the typical policy for the year 2000.

Al Gore and Joe Lieberman will bring Medicare up to date. They will take on the big drug companies to give a real prescription drug benefit to all seniors under Medicare. They will allow Americans between the ages 55 to 65 — the fastest growing group of uninsured in the country, and some of the most vulnerable to the vagaries of the private market — to buy into Medicare to get the health coverage they need. They will make Medicare more flexible and nimble, as well as make preventative benefits more accessible.

Medicare and the care it provides has always been a reflection of our oldest values of honoring our mothers and fathers. The steps proposed by Al Gore and Joe Lieberman will put modern medicine’s cutting-edge to work for all who need them, and bring Medicare into a new century — stronger and better than ever before.
CHAPTER 4:
MODERNIZING MEDICARE

Al Gore and Joe Lieberman believe that just improving Medicare’s benefit package is not enough. They believe we must also ensure that Medicare is modernized so that it will offer the right kind of choices for the people who depend on it in a way that is more competitive and more efficient.

They have a plan that, for the first time, would have health providers compete for the business of seniors on the basis of both quality and price, saving money for beneficiaries and making Medicare more efficient. The Gore-Lieberman plan will also ensure sound management of Medicare, cracking down on fraud, waste, and abuse, and takes important steps to rationalize cost sharing, reform Medigap, and ensure adequate provider payment rates. These policies, together with the Medicare lockbox described in Chapter 2, will extend the solvency of Medicare to at least 2030.

Al Gore and Joe Lieberman will continue to make Medicare more competitive by expanding and ensuring choice without forcing seniors into HMOs. They will ensure that seniors and people with disabilities can choose their own doctor, the medicine that their doctor recommends, and the health plan that makes sense for them – whether it is traditional care or managed care.

The Gore-Lieberman Plan takes other steps to improve Medicare and the choices it offers by making it harder for HMOs to drop seniors by increasing penalties on those that do and by forbidding “cherry-picking,” a practice that leaves some seniors without quality choices.

I. IMPROVING PRICE COMPETITION IN MEDICARE MANAGED CARE

While most of the 39 million Medicare beneficiaries receive care through traditional fee-for-service Medicare, about 6 million, or 16 percent, have chosen to enroll in a Medicare managed care plan. Medicare managed care grew rapidly in the 1990s because high payment rates allowed plans to use extra benefits – especially prescription drugs – to attract beneficiaries. There are no standards for what types of benefits plans may offer and few plans offer the same benefits. These non-standardized, additional benefits make it difficult for an “apples-to-apples” comparison that is needed for true price and quality competition. For example, it is
not clear whether an uncapped drug benefit with a $50 premium is more valuable than a capped benefit, with no premium and extensive preventive services.

Not only do variable benefits decrease beneficiaries’ ability to choose the highest quality and lowest cost plan, but it encourages “cherry picking.” Since managed care plans operate within a fixed capitation payment that is only partially adjusted for the risk of the enrollee, managed care plans have strong incentives to discourage sick, high-cost beneficiaries from enrolling. That results in managed care plans tailoring extra benefits to attract healthy and discourage sick enrollees. For example, many plans offer coverage of medical emergencies when traveling abroad or health club memberships, but few cover services like personal assistance needed by people with chronic illness.

True Price and Quality Competition as a Part of Medicare

Al Gore and Joe Lieberman’s Medicare plan would, for the first time, inject true price and quality competition into Medicare. Here’s how would it work. First, the plan would guarantee the same Part B premium for those remaining in the traditional fee-for-service Medicare program, while also allowing beneficiaries to pay lower premiums for choosing efficient private plans. Second, beneficiaries would have their Part B premium reduced by 75 cents of every dollar of savings that the private plan generates. Third, price competition would make it easier for beneficiaries to make informed choices about their plan options and would, over time, save money for both beneficiaries and the program.

The ability of this competition to work effectively is linked to the Gore-Lieberman plan to add a Medicare prescription drug benefit which creates a level playing field between traditional Medicare and managed care plans. It frees beneficiaries from seeking out managed care plans only because they need prescription drug coverage and ensures that these plans compete on cost and quality. Advantages of this plan include:

- **Savings through competition, not through legislated rate reductions.** By giving seniors the power to make real choices – not pressured ones – in Medicare, Medicare spending would be lowered as a result of seniors’ choices, not due to legislated rate reductions. In the long-run, it would make Medicare more efficient – without pressuring seniors into HMOs, as other reform plans do.
Promoting fair competition between managed care and traditional Medicare. This proposal bases its price competition on a central concept: beneficiaries choosing more expensive plans would pay more than traditional Medicare, and those choosing less expensive plans would pay less. This encourages fair competition between managed care and traditional Medicare, but does not penalize beneficiaries that believe that traditional Medicare best fits their needs, or force them into HMOs.

Maintaining a strong, viable, competitive traditional Medicare program. Al Gore and Joe Lieberman are committed to strengthening and improving the traditional program, which serves over 80 percent of all Medicare beneficiaries. The premium for traditional Medicare would be set as it is currently and, in fact, would be lower than current law due to the increased efficiency in the traditional program. This guarantees that traditional Medicare is an affordable option, so that beneficiaries have true choice of traditional care or managed care and, where there is no managed care, a strong, viable traditional Medicare program.

The table below shows how this system would work in an average cost area. It assumes that the Part B premium is $50 per month (slightly higher than today’s $48.50 per month).

Low-price plan. If the managed care plan’s price were $67 or 17 percent lower ($433), then the beneficiary would have no premium payment.

Medium-price plan. A beneficiary choosing a medium-price managed care plan which costs $10 less ($490) would keep 75 percent of that savings, or $7.50. As a result, his or her premium would be $42.50 rather than the $50 Part B premium. The government payments would also be reduced, by 25 percent of the savings. Its payment would be $447.50 rather than $450 (a savings of $2.50 per month).

Equal to 96 Percent of Traditional Plan. A beneficiary choosing a managed care plan whose bid is slightly less than traditional Medicare ($500) would pay the same premium that he or she would pay to stay in traditional Medicare – $50. The government would make the same managed care payment in this case as under the current system (total payments to plans equal 96 percent of traditional program costs).
### Example: Competitive Defined Benefit Proposal

<table>
<thead>
<tr>
<th>Option</th>
<th>Plan Price (monthly)</th>
<th>Split of Plan Payments</th>
<th>Beneficiary</th>
<th>Government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-Price Plan</td>
<td>$433.33</td>
<td>$0.00</td>
<td>0%</td>
<td>$433.33</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Medium-Price Plan</td>
<td>$490.00</td>
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<td>9%</td>
<td>$447.50</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td>Price Equals 96% of Traditional Costs</td>
<td>$500.00</td>
<td>$50.00</td>
<td>10%</td>
<td>$450.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** The beneficiary premium rate is $0 for managed care plans whose price is about 80 percent of traditional Medicare program costs (the exact level where this occurs would depend on what percentage the Part B premiums is of total Medicare when the system goes into effect).

### II. MODERNIZING TRADITIONAL MEDICARE, AND FIGHTING FRAUD, WASTE, AND ABUSE

Recognizing that four out of five beneficiaries choose to remain in traditional Medicare, Al Gore and Joe Lieberman will work to provide the program with tools that the private sector has successfully used to make health care delivery more efficient and higher quality. They also will build on this Administration’s strong commitment to cutting down on fraud and abuse which has saved more than $50 billion in fraudulent health care claims. They will work to remedy flawed provider payment policies from the Balanced Budget Act of 1997. And, they will rationalize Medicare’s cost sharing and Medigap policies, aligning them with typical private health insurance plans.
Giving Traditional Medicare Private Purchasing and Quality Improvement Tools, and Reducing Fraud

In the past decade, private purchasers of health care have developed effective techniques that target both beneficiaries with special health care needs (recognizing that they account for a large share of costs and could benefit from care management) and high-quality, efficient providers (to provide an incentive to improve care and reduce costs). Currently, Medicare has little statutory authority to implement these types of strategies, and less ability to reward providers of high-quality, cost-effective care.

The National Academy for Social Insurance has called for Health Care Financing Administration (HCFA) to be given greater flexibility to use these types of private sector tools in Medicare. In addition, HCFA, through demonstrations, has been exploring for several years arrangements for paying providers and plans to encourage high-quality care.

Al Gore and Joe Lieberman would authorize a broader use of the best practices from the private sector where applicable and feasible. For example, it would allow Medicare to use competitive pricing for current Medicare services so that prices for certain medical supplies or equipment could be set through competition rather than through a statutory rate formula. It would create the authority to contract for disease management services that have demonstrated higher quality, coordinated care for beneficiaries with chronic illnesses such as asthma and hypertension. It would also allow for case management of low-income seniors eligible for both Medicare and Medicaid, helping them navigate both systems. Finally, Al Gore and Joe Lieberman will propose a number of proposals to combat fraud, waste, and abuse. This follows on the recommendations of the Office of the Inspector General and the General Accounting Office.

Ensuring Adequate Payment Rates to Health Care Providers

In order to guarantee quality care, Al Gore and Joe Lieberman will ensure that payment rates are adequate to achieve quality care. Al Gore and Joe Lieberman will dedicate $40 billion over 10 years on the OMB baseline ($42 billion over 10 years on the CBO baseline) to ensure that Medicare and Medicaid provider payments are adequate to ensure high-quality care. Al Gore and Joe Lieberman believe that some of the policies included in the Balanced Budget Act of 1997 need modification, including payment policies affecting hospitals, rural providers, teaching facilities, home health care agencies, nursing homes, managed care plans, and other providers.
They will do this in a targeted way that balances the need for adequate reimbursement with the goal of keeping Medicare’s overall per capita cost growth in line with that of the private sector.

**Rationalizing Cost Sharing and Reforming Medigap**

The Gore-Lieberman plan would rationalize cost sharing requirements for Medicare by reinstating 20 percent coinsurance and the Part B deductible for clinical laboratory services. The modest lab copayment would help prevent overuse and reduce fraud. It would also index the Part B deductible for inflation. The deductible has been $100 since 1991 and has only been raised three times since Medicare was created. Compared to average annual Part B per capita costs, the deductible has fallen from 28 percent in 1967 to about three percent in 2000. Under this plan, the deductible would keep pace with inflation.

The Gore-Lieberman plan would reform private insurance policies that supplement Medicare (Medigap) by: working with the National Association of Insurance Commissioners to add a new option with low copayments and to revise existing plans to conform with the Gore-Lieberman proposals; directing the Secretary of HHS to determine the feasibility and advisability of reforms to improve supplemental cost sharing in Medicare; providing easier access to Medigap if a beneficiary is in an HMO that withdraws from Medicare; and including people with disabilities and end stage renal disease (ESRD) in the initial six-month open enrollment.

**III. PROMOTING REAL CHOICE ON PRESCRIPTION DRUGS**

Al Gore and Joe Lieberman are committed to promoting the types of choices that Medicare beneficiaries want, such as a choice of health plans and a choice of doctors within traditional Medicare.

**Increasing Medicare Managed Care Plan Choices**

The Balanced Budget Act of 1997 created the Medicare+Choice program to provide a wider range of Medicare health plan choices as well as to correct excessive payments. However, few alternatives to HMOs have joined the program, and the HMOs themselves have not been reliable partners for Medicare. Recently, many HMOs have reduced or terminated participation in Medicare+Choice. In 2001, 65 HMOs will not renew their Medicare+Choice contracts, affecting nearly one million seniors and adding on to the nearly 700,000 seniors forced to switch plans in 1999
and 2000. While the majority of these beneficiaries live in areas where there are other managed care plans, about 17 percent, or 159,000 seniors, will be left with no other HMO option, and few, if any, options for affordable drug coverage. All beneficiaries affected by these withdrawals can return to fee-for-service Medicare.¹

At the same time, HMOs have significantly reduced the generosity of their prescription drug coverage. For example, in the last two years, the proportion of plans that limit drug coverage to $500 or less has increased by 50 percent. This year, about 75 percent of plans are limiting prescription drug coverage to $1,000 or less per year.

HMOs have tried to place the blame for dropping and scaling back coverage on the Balanced Budget Act of 1997, which reduced the excessive payments that were made to HMOs. Recent reports from both the General Accounting Office (GAO), Medicare Payment Advisory Commission (MedPAC), and the Department of Health and Human Services Inspector General, contradict the HMO industry’s assertion that Medicare payment rates are inadequate for them to remain competitive. In fact, in 1998, Medicare spent more on beneficiaries enrolled in HMOs than for those in fee-for-service – 13.2 percent more. Not only are HMOs being paid more, but HMO enrollees are disproportionately healthier and thus, less costly. Finally, GAO concludes that the 1997 payment adjustments removed only half of the excess payments, resulting in 8 percent in excess payments to plans. This means that in 1998, payments for enrollees in HMOs ran $1,000 more than if the enrollee had received care in a fee-for-service program, for a total of $5.2 billion in additional payments. Specifically, the GAO found that “it is largely these excess payments, and not managed care efficiencies, that enable plans to attract beneficiaries by offering a benefit package that is more comprehensive than the one available to fee-for-service beneficiaries while charging modest or no premiums.”

Still, HMOs represent an important option for beneficiaries – particularly as an alternative to private and costly alternatives such as Medigap. The Gore-Lieberman plan will use financial incentives and penalties to improve choice of health plans. On the incentives side, as described previously, the plan creates a new competitive system for paying managed care plans. This will increase the stability in the system. Second, direct payment for prescription drugs would infuse over $80 billion over 10 years to ensure that seniors who choose HMOs will have a meaningful

<table>
<thead>
<tr>
<th>YEAR</th>
<th>BENEFICIARIES AFFECTED</th>
</tr>
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<tr>
<td>2001</td>
<td>934,000</td>
</tr>
<tr>
<td>2000</td>
<td>327,000</td>
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<tr>
<td>1999</td>
<td>407,000</td>
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drug benefit, with more choices and healthcare options. Third, the restoration of provider payment reductions in the Balanced budget Act will result in increased payments to managed care plans by approximately $7 billion over 10 years. Finally, the plan will work towards implementing an appropriate risk adjustment policy so that plans will get higher reimbursement for enrolling higher risk beneficiaries.

IV. PENALIZING HMOS WHO DROP SENIORS

Al Gore and Joe Lieberman believe that HMOs have a responsibility to the people who depend on them to cover their care, and there should be strong disincentives to keep HMOs from violating that trust, and strong punishment for them if they do.

Doubling Penalties for HMOs Who Drop Medicare Seniors

Under current law, HMOs who pull out of a community – leaving beneficiaries in a lurch – cannot return to that community for two years. While this penalty is designed to give plans incentives not to go in and out of service market areas, it clearly is not sufficient to discourage Medicare pull outs.

That is why Al Gore and Joe Lieberman are proposing to double this penalty – extending the exclusion period to four years. This new Gore-Lieberman proposal will discourage HMOs from dropping out of the program on a whim and leaving beneficiaries with unstable coverage – by making sure that HMOs which do so pay the price.

Requiring HMOs to Sign Up For Two Year Contracts To Ensure Beneficiaries More Stable Health Care Coverage

Today, all HMOs only sign up for participation in the Medicare program for one-year contracts. This period is so short that it ends up increasing the likelihood that beneficiaries will sign up for an HMO for one year – only to see that HMO pull out of the market.

That is why Al Gore and Joe Lieberman will propose legislation that contracts will be required to run at least two years to ensure that beneficiaries have coverage they can count on. A two-year participation period will make it harder for HMOs to withdraw from coverage, increasing the reliability and stability of the program.
Penalizing Medicare HMOs Who Cherry Pick Healthy Beneficiaries

There are some Medicare HMOs who participate in Medicare who stay in the program and serve a range of beneficiaries in a range of areas. However, there are too many who choose to only participate in “healthy areas” – cherry picking those communities where it is more profitable to cover seniors. These bad apple HMOs put those who play fair at a disadvantage and undermine the entire market.

That is why the Gore-Lieberman plan proposes new rules to ban plans from participating in Medicare if they clearly only cherry pick healthy communities and pull out of other Medicare areas. These HMOs will get a warning – and if the practice persists they will be banned from participating in Medicare altogether.

Choice of Doctors

It must be remembered that even as the Gore-Lieberman seeks to create new managed care choices, it also maintains a strong, viable traditional program. The traditional program’s premiums would be protected and the ability to see the beneficiaries’ doctor of choice would be maintained.

V. CHOICE OF PLANS, NEEDED DRUGS AND PHARMACIES WITH THE PRESCRIPTION DRUG PLAN

The Gore-Lieberman Medicare prescription drug plan includes the type of choices that matter to seniors and people with disabilities. These include:

• **Choice of prescription drugs in all health plan options.** Seniors will have the option to choose to get their prescription drug benefit through Medicare fee-for-service, a managed care plan, or retiree health coverage if available. There is no requirement to join the traditional fee-for-service program, and employers will receive financial incentives to continue offering prescription drug coverage as part of their retiree health package.

• **Guaranteed coverage of the drugs their physicians choose to prescribe.** Because Medicare beneficiaries often have multiple, complex health problems, the Gore-Lieberman plan would cover any drug that a doctor certifies in medically necessary. Plans cannot adopt rules that limit access or impose burdensome appeals processes. If a drug is medically necessary, a senior can get it, whether it is on- or off-formulary.
• **Choice of which pharmacist they use.** Under the Gore-Lieberman plan, Medicare beneficiaries would be allowed to purchase their drugs at any qualified pharmacy, allowing them to go to the pharmacist that they trust. This will allow seniors and people with disabilities to go to their local community pharmacist, rather than being forced to travel to an unfamiliar pharmacy to meet the conditions of their drug plan.

**VI. THE BUSH PLAN INCREASES PREMIUMS AND FORCES SENIORS INTO HMOs**

George W. Bush says he also supports more choice for Medicare beneficiaries. His plan for competition is based on the approach taken by the Medicare Commission – and approach that did not garner enough support to be recommended to Congress.

The premium support restructuring proposals put forth in the Medicare Commission (and in the companion legislation) would change the way that Medicare is reimbursed. This policy would allow health plans to bid on how much it would cost them to provide Medicare benefits. Medicare would then reimburse for 88 percent of the average bid for the average plan. (The 88 percent is derived from the current premium formula). Beneficiaries would pay difference in premiums.

The idea is that Medicare beneficiaries would pay the same premium that they do today if they enrolled in an average cost health plan. As an incentive for beneficiaries to enroll in lower cost plans, if they joined a below-average cost plan, they would save money in premiums and so would the Medicare program. However, if they chose an above-average plan, the beneficiary would have to pay a higher premium.

Fee-for-service traditional Medicare plans would no doubt come in at a higher-than-average cost and therefore mean higher premiums for any Medicare beneficiary who wanted to stay in traditional Medicare rather than go into an HMO. The HCFA actuaries estimated last February that the increased premiums beneficiaries would have to pay to stay in fee-for-service Medicare would be quite significant – between 25 percent and 47 percent more than the premium they pay today. This would mean that for beneficiaries could pay an increased premium of as much as $66 per month. As many beneficiaries could not afford this increase (today’s premium is $45.50 per month), they would be forced to join a cheaper managed care plan. This type of plan may or may not pay for the doctor that the beneficiary has used for years.
The Bush plan would also fail to provide Medicare beneficiaries with the types of choices that they want in prescription drugs. In the first four years, it would leave out millions of seniors who currently lack prescription drug coverage, effectively denying them access to prescription drug coverage. Seniors who will have access would need to get it through their state plans. In addition, if funding is inadequate, there may be waiting lists.

Even in the second phase of drug coverage under Bush plan, seniors’ drug choices would be limited. It would provide coverage through private insurers who would be allowed to impose burdensome restrictions on the drugs that seniors can take and would not guarantee that they could go to the pharmacist of their choice. The Bush plan would push seniors into HMOs, which would also fail to provide a strong, guaranteed prescription drug benefit.

**VII. CONCLUSION**

Taken together, the Gore-Lieberman proposals will make Medicare more efficient and competitive. It will cut down on fraud and abuse, and at the same time, make sure that beneficiaries are protected from unfair cost increases and gain the types of choices that they want. Seniors and Americans with disabilities deserve a strong Medicare program, and Al Gore and Joe Lieberman are committed to making sure they have quality health care through a stronger, modernized Medicare program.
CHAPTER 5
A DIFFERENT PATH:
THE BUSH-CHENEY APPROACH

This election presents a fundamental choice to voters when it comes to Medicare. Al Gore and Joe Lieberman will put Medicare in an ironclad lockbox where it can not be raided by politicians, and will devote part of the surplus to keeping Medicare solvent until at least 2030. The Gore-Lieberman plan will strengthen Medicare by adding a real prescription drug benefit to it. And their plan will make Medicare more competitive, efficient, and will improve the choices it offers.

By contrast, the Bush-Cheney plan is fundamentally flawed. Governor Bush and Secretary Cheney support an agenda that would completely restructure Medicare into a program where seniors would be forced into private insurance plans and HMOs. This policy, known as “premium support,” Governor Bush claims, would lead to more choices of plans. However, Medicare’s independent actuaries confirm that premiums in fee-for-service Medicare would significantly increase under a Bush-style competition plan. Facing higher premiums in traditional Medicare, millions of seniors would be left with little choice except to join an HMO under the Bush-Cheney plan, whether they want to or not. Equally flawed is their approach to prescription drug coverage. Governor Bush and Secretary Cheney rely on a state-based, means-tested prescription drug option – that the states themselves have rejected. Then they depend on a private insurance model for prescription drug coverage – one that insurers themselves have rejected.

The Bush-Cheney plan demands careful scrutiny. The American people deserve to examine any proposal that will so radically alter Medicare and potentially undermine the fundamental commitment implicit in it.

I. THE BUSH APPROACH WOULD ALTER MEDICARE’S COMMITMENT TO AMERICA’S SENIORS AND FORCE THEM INTO HMOS

Governor Bush and Secretary Cheney do not provide much detail about their Medicare plan, but they do indicate that their Medicare restructuring plan would resemble the failed Medicare Commission’s so-called ‘premium support’ plan. This approach is intended to make Medicare into a system more based on choice and competition. Ostensibly, it does this by providing seniors with a defined amount of premium support (similar to a voucher) to choose between a variety of private and
public plans. Seniors would pay, out-of-pocket, any premium costs above that
defined amount. This proposed change – even without evaluating the effect on
regular Medicare premiums or patient satisfaction with HMOs – represents a
tremendous, and corrosive, change to the Medicare system.

How Premium Support Proposals Work

Premium support proposals allow health plans to bid on how much it would
cost them to provide Medicare benefits. Medicare would then reimburse for a
portion of the average bid for the average plan. Beneficiaries would pay the
difference in premiums. If they enrolled in an average cost health plan, they would
pay the same amount they pay today. However, if they chose an above-average cost
plan, the beneficiary would have to pay a higher premium.

Medicare’s own independent actuaries have confirmed that fee-for-service
traditional Medicare plans would come in at a higher-than-average cost; thus, any
beneficiary who wanted to stay in traditional Medicare rather than go into an HMO
would have to pay higher premiums.

In fact, last February Medicare actuaries estimated that the increases
beneficiaries would have to pay to stay in traditional Medicare would be quite
significant – between 25 percent and 47 percent more than the premium they pay
today.¹

This would mean that beneficiaries could pay an increased premium between
$272 and $512 per year, per couple. As many beneficiaries could not afford this
increase (today’s premium is $45.50 per month), they would be forced to join a
cheaper managed care plan run by an HMO.
In addition to this basic increase in premiums for traditional Medicare, experts agree that a proposal like Bush’s would create a variety of market pressures that would increase premium prices further. As one newspaper noted, “Critics assert that under such systems, the government-allotted premium – particularly if it is tied to a national average of bids from the major health plans – will never keep up with the cost of the traditional Medicare program.”

The non-partisan Lewin Group argues that a shift to a defined contribution system essentially changes the compact with America’s seniors that is Medicare, turning it into a voucher system. They observe that, “the voucher model would convert Medicare from a ‘service reimbursement’ system to a ‘premium support’ system.”

II. THE BUSH APPROACH FORCES SENIORS INTO HMOS WITHOUT EXTENDING THE SOLVENCY OF MEDICARE

As the Washington Post reported, many analysts believe that the Bush plan would force millions of seniors into private health insurance plans and HMOs. Instead of strengthening and modernizing Medicare’s benefit package for all seniors, Bush’s plan would tell seniors to go and try themselves to find a plan that meets their needs.
needs. While doing this, Bush’s plan would raise the cost of traditional fee-for-service Medicare, effectively pushing seniors into private insurance plans and HMOs.

The Bush Model Offers No Choice for Many

Al Gore and George Bush agree that Medicare beneficiaries should be allowed to choose the health care coverage that best meets their needs. Under Al Gore’s plan, seniors would have the choice to stay in traditional care or managed care. While Bush’s plan claims to create choice, it forces beneficiaries to join private insurance plans and HMOs. The clear impact of raising the premiums for those who are in traditional care is to leave many seniors with no choice but to move into an HMO – hardly a choice at all.

Other Commission proposals praised by Bush

The list of controversial policies that are part of the failed Medicare Commission plan that Bush has praised does not end with higher premiums for traditional Medicare and moving seniors into private insurance plans and HMOs.

The Commission’s recommendations also include new co-payment for home health services. Specifically, they include new co-payments of 10 percent for home care visits. Families USA, “The Breaux-Thomas Proposal: What Will it Mean for Medicare Beneficiaries?” 3/12/99 That means that an elderly widow living alone – the typical home care recipient – could pay over $600 for services. This would add to the already-excessive long-term care costs that many American families face.

The failed Commission also would have: created a drug benefit limited to the low-income; raised eligibility age for Medicare; and merged Medicare’s trust funds rather than protecting them. In addition, Governor Bush has provided few details on any of these proposals – instead, stating that he will create a “White House Task Force on Bipartisan Medicare Modernization” to make recommendations.

Al Gore and Joe Lieberman believe that when it comes to an issue as important as Medicare and the care of our seniors, the American people deserve to know the details.

Bush Squeezes Seniors, but Does Not Extend Solvency

Despite the rhetoric about restructuring Medicare, Bush does not dedicate resources to extend the life of the Medicare Trust Fund. Even though the number of
elderly is expected to double over the next few decades, leaving enormous challenges for the program, the failed Commission’s recommendations do not include any new money to extend the solvency of the program. Governor Bush has failed to dedicate any new money to Medicare solvency. Furthermore, as the New York Times reports, “Health maintenance organizations and other managed care insurance plans, which could play a central role in Mr. Bush’s proposal, are no longer viewed as an easy cure-all that can both control health care costs and deliver better care.” Thus while Bush’s plan could easily leave seniors far more vulnerable under the Medicare program, he would not take steps to secure its future.

III. THE BUSH PRESCRIPTION DRUG COVERAGE PLAN: PHASE ONE

The Bush prescription drug benefit works in two phases. For the first four years – or all of the next Presidential term – Bush advocates a state-based approach to provide coverage. He then shifts to a private insurance model that provides a partial subsidy to plans offering drug coverage to middle class seniors.

According to the New York Times, “The Bush plan is inferior because it relies on uncertain action by states and the private sector, and would leave too many people without coverage for now.” While Governor Bush says he wants to fundamentally restructure Medicare, he proposed a temporary program that will provide only low-income seniors with only modest relief. His plan would provide $48 billion in to the states for four years as a transition to his more permanent plan to fundamentally reform and restructure Medicare. Bush claims this “Immediate Helping Hand” plan would states to offer prescription drug coverage for seniors earning up to 175 percent of poverty – or $14,600 for a single individual.

Leaves Out Middle Class Seniors – 25 Million – Throughout a First Term in Office

Throughout an entire Presidential term, Bush would explicitly exclude at least 25 million seniors, as his plans only cover seniors with incomes up to 175 percent of poverty: $14,600 for singles, and $19,700 for couples. Seniors with incomes above this amount get no help – nothing – from the Bush plan. These plans exclude 60 percent of all seniors and people with disabilities who lack drug coverage, and they exclude three out of every five Medicare beneficiaries with the highest drug costs. These seniors would be completely left out of the Bush plan – for at least 4 years.

Forty states would have at least 70 percent of their seniors ineligible for assistance under the Senate Republican low-income block grant. In fact, in 16 states,
the percent of excluded seniors is 75 percent or more, and in five states, the percent excluded is 80 percent or more. These seniors would be completely left out of the Bush plan – for at least four years.

**Coverage is Inadequate and Uneven**

Even if seniors are eligible to participate, most will not. And even those that do enroll will find that coverage would vary significantly from state to state. Some states could extend their current Medicaid or state drug assistance program benefits. Five of the 14 non-Medicaid state programs limit drug coverage to specific conditions or maintenance drugs. Fourteen programs limit the number of prescriptions that can be filled. For example, Texas, Oklahoma, and Wisconsin permit only three prescriptions per month. A state like Texas could continue to limit the number of prescriptions that seniors fill to three per month. Seniors, many of whom lack the mobility of younger, wealthier individuals, may not be allowed to obtain needed drugs from their local drugstore. And there appears to be no guarantee that seniors could obtain the medically necessary drugs their doctor prescribes. In addition, under most low-income plans, there is no guarantee that, when a doctor prescribes a particular drug as medically necessary, the patient would get it.

**Requires That Seniors Go Through Welfare Offices**

Only 16 states now operate programs to help low-income elderly people buy prescription drugs. Of these, Connecticut, Delaware, Maine, and Minnesota require seniors to apply to the welfare office for prescription drug coverage. The General Accounting Office reports that fewer than 800,000 people participate, and that many elderly people are reluctant to enroll because they have to go to welfare offices to sign up. In addition, less than 800,000 seniors are enrolled in state pharmacy assistance programs. These state-initiated programs have low participation rates and exclude more than 90 percent of Medicare beneficiaries in 8 of the 14 states with such programs. This is partially due to the fact that to sign up for these programs, eligible seniors often have to fill out long, complex applications; meet extensive documentation requirements for income and assets; and sign up through welfare offices.

Complex enrollment procedures contribute to the belief that state assistance is “welfare,” only for “poor people” and could jeopardize the financial well-being of spouses and children. Despite efforts to overcome this, these negative perceptions remain and serve as a significant barrier to enrollment, discouraging seniors from participating in low-income drug support programs and create unnecessary stigma.
for older Americans struggling to afford the medications that allow them to maintain their health. Some states, including Michigan and Rhode Island, require in-person interviews through their Departments of Aging. Other states require regular re-enrollment and proof of income in order to maintain benefits. Michigan and Wyoming require re-enrollment on a monthly basis.

Even States and Experts Reject This Approach

States have said they do not want to assume the cost and responsibility of running prescription drug programs. The bipartisan National Governors’ Association (NGA) explicitly rejected this idea during their Winter 2000 meeting. The NGA passed a resolution which said, “If Congress decides to expand prescription drug coverage to seniors, it should not shift that responsibility or its costs to the states.…” Governor Musgrove of Mississippi said of prescription drug block grants, “Many of the block grant programs are not well-intentioned. They have the complete aim of shifting the costs to the states.” Low-income advocates also reject this approach, because they know participation rates will be low and the benefit will be weak.

Plan Only Provides 625,000 Uninsured Seniors With Coverage.

When evaluating the states with drug coverage programs for low-income elderly, the total number of seniors with incomes below 175% of poverty – or approximately the total number of seniors potentially eligible for coverage support – is 9.1 million individuals. According to Dr. Ken Thorpe at Emory University this means those who are Medicaid eligible are disqualified. Since most states disqualify even low-income seniors who have access to employer-based or retiree coverage, the number of uninsured seniors eligible for these state programs shrinks to 3.9 million Americans. The National Academy of State Legislatures notes that 830,000 individuals in this year receive coverage through state-based plans. As a result, the state participation rate is 21.2 percent.

One of the most exemplary programs is Pennsylvania’s PACENET program. It is among the three largest state-run programs providing low-income seniors with prescription drug coverage. The program avoids several of the pitfalls of programs in other states – for instance, it is implemented through the Department of Aging and therefore not associated with traditional “welfare” programs. Furthermore, it enjoys a participation rate of 25 percent – which is higher than the average participation rate of the states with insurance coverage programs. Six other states have programs on the books, but not yet implemented.
However, using the Bush criteria for program eligibility and the generous 25 percent participation rate from Pennsylvania’s PACENET program, Dr. Ken Thorpe of Emory University estimates that only 625,000 currently uninsured seniors will obtain coverage from the “Immediate Helping Hand” program, assuming the program overcomes initial barriers and is successfully established in all 28 states that currently fail to either offer coverage today or have a plan on the books to offer coverage. Thorpe finds that there are 2.5 million uninsured Medicare beneficiaries in these remaining 28 states, and assuming a PACENET-type participation rate, the program, would result in only 625,000 previously uninsured beneficiaries who obtain coverage.\textsuperscript{13}

The bottom line is clear: of the 13 million seniors who now lack drug coverage, according to this analysis, only 625,000 would get it by the end of George W. Bush’s first term.

\textbf{NUMBER OF CURRENTLY UNINSURED SENIORS WHO OBTAIN PRESCRIPTION DRUG COVERAGE}

\emph{Gore-Lieberman Plan Would Cover 20 Times More Medicare Beneficiaries Than the Bush-Cheney Plan When Each Plan Is Implemented}
The Plan Would Not Be Enacted In A Timely Manner

For the first four years of Bush’s plan, $12 billion a year would be allocated to states for them to implement prescription drug programs. While he calls this program an “Immediate Helping Hand,” it is not realistic to expect the drug plans to begin immediately. Unlike an added Medicare benefit, which would be created with a single act of Congress, state legislatures would have to pass legislation establishing or expanding prescription drug coverage programs. The states which have no plan in place today would have to design and implement a program from the ground up. Each of these states would have to educate and enroll seniors in the new plan. Even the states which already have a plan in place would have to have their legislatures revise and expand the existing program.

For states which currently have no prescription drug program for seniors and whose legislatures meet biannually, including Texas, it is expected that they would not have a prescription drug plan in place until 2004 or 2005.

Given these barriers, it is extremely unlikely that all states would implement new prescription drug programs under this plan next year. Not only does the bipartisan National Governors’ Association oppose taking responsibility for prescription drugs, but the time-limited and inadequate funding in most plans would give states little incentive to invest in setting up new programs.

Even if states did support this approach, it would take time to implement. According to the New York Times, “…many [states] would have to create new bureaucracies to administer a new drug insurance program,” which can take years. When implementing a similar program in which federal money is allocated for states to use to provide health insurance for children whose parents are not eligible for Medicaid but still very poor, some state implementation was slow. The last three states started enrolling children in the bipartisan, state-supported Children’s Health Insurance Program just this year – three years after enactment. In Texas, it took two and a half years from when the money was first made available to when Texas began actually began covering children. According to Time magazine, “What’s more, experience with other programs—like providing drug benefits through Medicaid—suggests the states are far less efficient than the Federal Government at enrolling those who are eligible.” Finally, the federal “default plan” to provide coverage in states that do not participate could not be operational in 2001 because new systems for income-based eligibility would be needed.
It is clear that these low-income block grants would fail to help low-income beneficiaries but would succeed in delaying implementation of a Medicare prescription drug benefit. If enacted, the next Congress would likely spend more energy on fixing this flawed low-income plan than establishing an affordable, meaningful, and accessible Medicare prescription drug benefit option. More importantly, this interim step is not needed: Congress could pass a meaningful Medicare prescription drug proposal this year that would be available to all Medicare beneficiaries in 2002 and more effectively help low-income enrollees.

IV. THE BUSH PLAN, PHASE TWO: A PRIVATE INSURANCE MODEL THAT LEAVES MILLIONS OUT

Five years from today is a long time for an 85 year-old widow making $18,000 with no prescription drug coverage. But even when the five year old finally comes — and George W. Bush implements the second phase of this plan — she should not expect much. She will have to rely on a private insurance benefit that the private insurance industry itself says will not work. Even if it is available, the premium will cost 50 percent more for a benefit for a less valuable benefit than that offered under the Gore-Lieberman plan. And finally, even if she can afford the benefit, it may not provide her access to all the medically necessary drugs she needs and the pharmacist she trusts.

The second part of the Bush prescription drug plan would require every insurer participating in MediCARxES to offer an “expanded” or high option benefit, which includes prescription drug coverage and catastrophic protection. Bush would then provide a subsidy to help cover the additional cost of the prescription drug benefit.

Although the Bush plan does not specify the expected premiums or benefits of these prescription drug benefits, Bush does offer a subsidy structure to provide seniors some support to purchase the more expensive coverage options which include drug benefits. The plan would cover the full cost of drug benefit premiums for seniors at or below 135 percent of poverty, provide a partial premium subsidy for seniors with incomes between 135 and 175 percent of poverty, and provide a 25 percent premium subsidy for seniors with income above 175 percent of poverty. HCFA will be required to offer a drug benefit option in areas with no private coverage options.
Leaves More Than Half of All Seniors Out

The Bush approach will no doubt result in higher premiums and lower benefits. As a result, many seniors will be unable to afford coverage or will decide that their level of need, especially if they are healthy, does not warrant the expenditure. This study builds on the Congressional Budget Office evaluation of H.R. 4680. That evaluation noted that, “Of those who purchase Part B but do not have drug coverage, CBO assumes that 46 percent purchase a qualified drug plan.” Similarly, a CBO scoring of such a drug benefit found that one-third of the uninsured would not take up the prescription drug option.21

Private Insurers Say They Will Not Participate

The reaction of private insurance representatives to various private coverage options underscores how unworkable the Bush approach actually is. The private insurance industry has already noted that stand-alone prescription drug benefits are not feasible.22 Blue Cross/Blue Shield noted that “to pass legislation to provide access to such coverage would constitute an empty promise to Medicare beneficiaries.”23 The Bush plan does not rely on stand-alone coverage, but some private insurance representatives remain skeptical about combined medical and prescription drug benefits for seniors – citing the increasing number of HMOs that are going beyond cutting back on benefits by actually dropping Medicare beneficiaries from their plans.

There is only state where this type of insurance model has been tried, and it met with limited success. Nevada launched a prescription drug plan last year to be administered by private insurers. It opened up to about 800 insurers but no eligible insurer signed up. Although the state recently announced that it found one qualified insurer, this case highlights the problems of this model.24

Do Seniors Get the Prescriptions Their Doctors Recommend?

The Bush plan does not specify that seniors and their doctors would have access to all medically necessary drugs. Since the plan requires seniors to obtain private drug coverage, these private insurers and HMOs would be able to determine which drugs are covered. Without explicit provisions stating that plans would be required to cover any medically-necessary drug – as determined by doctors and patients, not insurers – the Bush plan cannot guarantee that seniors, and their medical providers, would be in control of medical decision-making. In similar legislation, if the plan denies coverage of a particular prescription, the doctor is required to go through a time-consuming appeal to ensure the prescription is
covered. Under the Gore plan, if a doctor recommends a prescription, the beneficiary will receive it.
PRESCRIPTION DRUG PLANS FOR REAL PEOPLE

The following example shows what a prescription drug benefit would mean to Mrs. Jones, a widow who needs to purchase $610 of prescription drugs per month ($7,320 per year) in order to treat her hypertension and arthritis. Her income from Social Security and her pension is $16,000 per year. Currently she is one of the thirteen million seniors who have no coverage for prescription drugs. As a result, she must pay the full $7,320 per year out-of-pocket for her drug benefit.

Under the Gore-Lieberman plan, Mrs. Jones would pay a modest premium – $25 per month – for a meaningful prescription drug benefit that limits her out-of-pocket expenses for prescription drugs to $4,000. In net, she will save $3,020 annually on her prescription drug costs.

Under the Bush-Cheney plan, three out of five Medicare beneficiaries without coverage will not be eligible for any coverage from their “Immediate Helping Hand.” While some States may provide a $6,000 stop-loss, this woman lives in a state where that protection is only available to low-income beneficiaries. In addition, to remain in traditional Medicare, she will have to pay more in the “premium support” system. If Mrs. Jones did live in a state with a $6,000 catastrophic protection for all seniors, then her savings would still be at least $2,106 less than under the Gore-Lieberman plan – not taking into account any premiums she may be charged.

<table>
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<tr>
<th>Current Law</th>
<th>Gore-Lieberman</th>
<th>Bush-Cheney</th>
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<tbody>
<tr>
<td>Cost of Prescription Drugs</td>
<td>$7,320</td>
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<tr>
<td>Discount</td>
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<tr>
<td>Paid by Beneficiary</td>
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<tr>
<td>Premium for Medicare Outpatient Services</td>
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<tr>
<td>TOTAL SAVINGS</td>
<td>$3,020 in Savings</td>
<td>$118 in New Costs</td>
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²⁵ Calculated as $7,320 - $4,000
²⁶ Assuming no catastrophic coverage and no premiums.
²⁷ Calculated as the difference in premiums for traditional and Medicare Part D plans.
V. CONCLUSION

Governor Bush’s Medicare reforms and prescription drug plan would threaten the ability of seniors to receive consistent health care and preclude the development of a real, meaningful prescription drug benefit for all seniors. By restructuring Medicare to prioritize private insurers, including HMOs, Bush would alter Medicare’s fundamental commitment to senior Americans by trading in the guarantee of access to health services for “premium support,” so that seniors could move into private plans. Private plans, when compared to Medicare, have higher administrative costs than Medicare and could raise quality of care concerns for sick or chronically-ill Medicare beneficiaries. In creating a private, voucher-like system, the Bush-Cheney plan would increase premiums for traditional Medicare, push millions of seniors into private managed care plans, and increase the program’s cost structure without shoring up its Trust Fund for future generations.

Bush’s prescription drug plan is also woefully inadequate. The first four years of the plan gives blocks grants to states and asks them to design and implement a prescription drug plan, which they have already indicated they do not want to do. Less than half the states currently have a plan in place, which not only questions whether the remaining states would choose to assume that responsibility, but also illustrates the difficulty of significantly increasing state participation in this voluntary plan. The Bush-Cheney campaign speaks of the plan’s “immediate” implementation, but the reality of the plan’s shortcomings are more significant than the campaign’s rhetoric. Even assuming that all states without an existing plan take up the program, only 625,000 currently uninsured seniors will gain coverage. In fact, even if every eligible senior takes up coverage, the plan will exclude 25 million middle class seniors. Phase two of the Bush plan, which is not implemented until a second presidential term, also excludes millions of uninsured seniors. The plan would also rely on HMOs and insurance companies to provide a benefit that promises to provide more for less.

The commitment Al Gore and Joe Lieberman bring to Medicare, outlined in the previous pages, can be summarized simply: Al Gore and Joe Lieberman believe that our obligation to provide the best care for those who have cared for us should be at the forefront of our nation’s Medicare policy. That is why they have proposed a different approach – one that will honor our parents, provide for them the best of modern medicine, and strengthen our economy in the process. Their plan prepares Medicare to meet its coming challenges, and prepares America to meet the challenge of an aging nation.
NOTES

Chapter 1: Medicare: A History of Success, a Future of Challenges

1 HCFA, Medicare 2000.


3 HCFA, Medicare 2000.


7 HCFA, 2000.


Chapter 2: Protecting Medicare

1 New York Times, 9/13/00.

2 Medicare Trustees Report, 3/00.

3 CBO, 7/00.

4 Letter to the President, August 21, 2000.

5 Calculations based on Medicare Trustees Report, 3/00.

6 CBO March baseline.

Chapter 3: Improving Medicare


Chapter 5: A Different Path: The Bush-Cheney Approach

1 Letter From Richard S. Foster, Office of the Actuary, HCFA, to Ways and Means Health Subcommittee Minority Staff, 2/23/00.


4 *Washington Post*, 9/15/00

5 www.georgewbush.com; Testimony of Senator Rockefeller, 7/22/99

6 *New York Times*, 9/12/00

7 Low-Income Prescription Drug Plans, National Economic Council, 9/00


9 Low-Income Prescription Drug Plans, National Economic Council, 9/00


11 NGA resolution, adopted Winter Meeting, 2000

12 *Associated Press*, 9/15/00

13 Thorpe study. This analysis assumes that states with existing plans do not expand their current programs. Thorpe argues that current program eligibility criteria in existing states are similar to the Bush plan’s eligibility criteria. As a result, he notes that if these states choose to draw down additional Federal funding, those resources would be dedicated to improving the plan’s benefits package, not loosening eligibility rules.

14 Bush Medicare Fact Sheet, 9/5/00

15 *Wall Street Journal*, 9/15/00

16 CNN, “Inside Politics,” 9/11/00

17 *Wall Street Journal*, 9/15/00

18 *Wall Street Journal*, 9/18/00

19 *Time*, 9/18/0

20 Bush Medicare Fact Sheet


22 *National Journal*, 4/1/00; *AP*, 6/13/00

23 *National Journal*, 4/1/00; *AP*, 6/13/00

25 Assumes a conservative 10 percent price discount, which is consistent with CBO estimates.

26 The Gore-Lieberman plan has a catastrophic benefit that limits expenses to $4,000.

27 Medicare actuaries assume that the Part B premium would be at least 18 percent higher under this proposal.